Caught in a trap

The Long-term Homeless: A Profile of Needs and Service Use

Houghton, F.T., Hickey, C.

Table of Contents

List of Figures

List of Tables

Acknowledgements

The authors would like to thank the following:
Homeless Initiative for funding this research
Orla Barry, Focus Ireland
Kieran Stenson, Focus Ireland
Mark Kane, Focus Ireland
Fiona Lorden, Focus Ireland
Focus Ireland Crisis Team, Outreach and Extension staff
Caroline Corr

Executive Summary

This research project examined the needs, circumstances and service use of a sample of the long-term homeless. The research emerged as a response to the observations of Focus Ireland staff that an increasing number of homeless people were getting caught in a trap of homelessness. The project had two elements. In the first, an interviewer-administered questionnaire was completed in consultation with 25 people who had been homeless for more than six months and were being key worked by the Extension, Outreach or the Crisis Teams within Focus Ireland. The second element involved tracking the circumstances and service use of a sample of 44 long-term homeless (including the original 25) over a three-month period. The results from both elements of the study were alarming. The results show a transient population with frequent accommodation moves. Family conflict and relationship breakdown accounted for homelessness in over a third of cases. However drug related problems were cited as the primary cause in another 20 per cent of cases.

The mental health among the original sample of 25 participants was significantly worse than that of the general Irish population, as measured by the SF-12. The group also recorded poor physical health, including one case of Tuberculosis and 4 of Hepatitis, as well as a variety of other illnesses. Sixty-eight per cent (17) of this sample had ever used illicit drugs. The rate of current use was little different at 65 per cent (16). An issue of particular concern is the rate of poly-drug use; almost half of the respondents were currently using more than one illicit drug. Significant alcohol addiction problems were also noted, as indicated by the CAGE questionnaire.

The longitudinal element of the questionnaire identified continued accommodation changes as well as ongoing mental and physical health problems. Frequent hospital admission was noted, as was problem drug-misuse. Over 20 per cent of the sample was incarcerated at least once, or had cases heard or postponed during the 3 month tracking period.

Key recommendations arising from the findings of the research include addressing issues of the provision of medical services and drug treatment therapies based on identified and assessed need and ease of access. The recommendations call for more emergency accommodation in addition to more move-on and supported transition housing to help move people out of the cycle of homelessness.

1.0 Background to the Study

This research project emerged as a response to the observations of Focus Ireland staff on the ground, that an increasing number of homeless people were getting caught in the trap of homelessness. Concern was raised that despite the provision of services to aid the re-integration of homeless people into mainstream society, provided by the State, by Focus Ireland itself, and by a host of other voluntary organisations working in this sector, more and more people were remaining homeless for protracted periods. A number of objectives were identified:

1. To develop a profile of the circumstances and needs of a sample of the long-term homeless.

2. To conduct a longitudinal analysis of service use and changing circumstances of a sample of homeless people over a three-month period.

3. To develop a set of recommendations based on the findings of the research.

2.0 Defining Homelessness

The aim of this research paper is not to discuss the contrasting and contradictory definitions of homelessness that exist or to describe the complexities of the development of relevant legislation. Comprehensive, in-depth reviews of Irish and international definitions (usually from the UK and the USA) have been conducted elsewhere (Cox & Lawless, 1999; O'Sullivan, 1996; Cleary & Prizeman, 1999). However it is important to state that the definition of homelessness provided in the 1988 Housing Act (see Box 1) is quite frankly inadequate and largely detached from the day to day operational activities of an organisation working with, and on behalf of, people out of home such as Focus Ireland.

Box 1.

A person shall be regarded .. as being homeless ... if:

(a) there is no accommodation available which, in the opinion of the authority, he together with any other person who normally resided with him or might be reasonably expected to reside with him, can reasonably occupy or remain in occupation of, or;

(b) He is living in a hospital, county home, night shelter or other such institution and is so living because he has no accommodation of the kind referred to in paragraph (a) and he is, in the opinion of the Authority, unable to provide accommodation from his own resources.

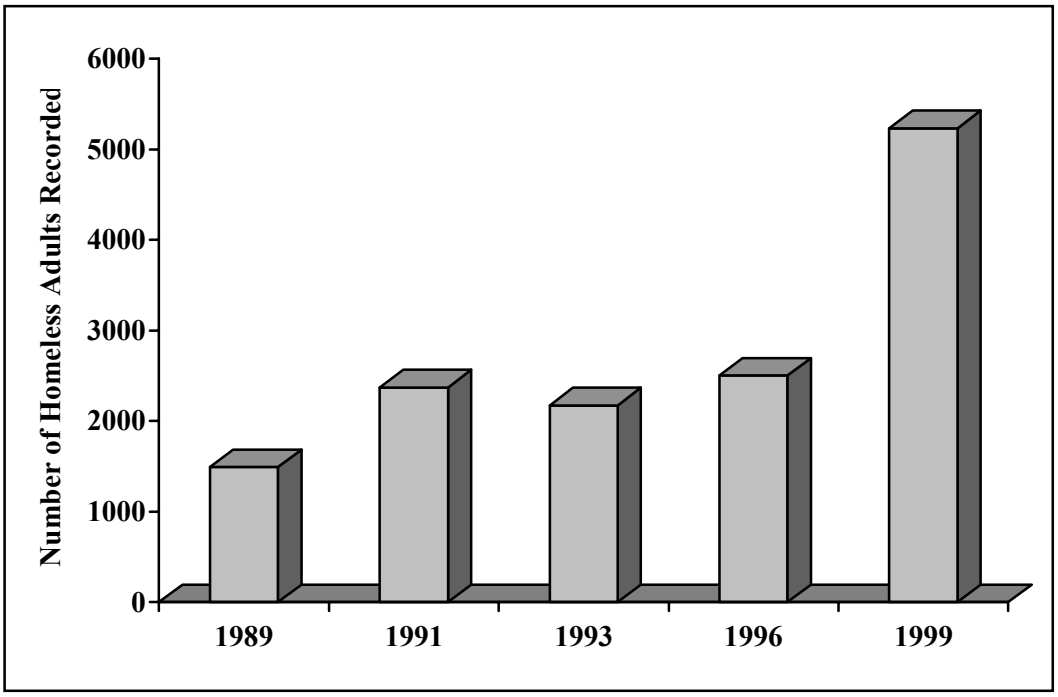
The daily activities of many Focus Ireland staff involve working with a significant proportion of people outside of the 1988 definition of homelessness, and yet are either homeless or at high risk of homelessness. The definition has been noted to exclude the 'hidden homeless' (O'Sullivan, 1996) and those in B&B accommodation (Cleary &

Prizeman, 1999). The definition clearly excludes those at risk of homelessness. This exclusion is an issue of grave concern given the cycle of homelessness and temporary housing many homeless people repeatedly experience. Such cycles have been frequently noted both in Ireland and abroad (Cox & Lawless, 1999; Anderson et al., 1993). Any practical definition of homelessness must accept homelessness as a continuum (Watson & Austerberry, 1986) and include all of its varying degrees, including insecure rentals and the 'at risk' (Redburn & Buss, 1986).

2.1 The Growth of homelessness in Ireland

As stated above the aim of this research is to examine the situation of a sample of the growing number of long-term homeless in Ireland. There are two aspects to this issue. First there is the issue of the growing number of homeless people in Ireland, while second there is the concern of the increasing length of time many people remain homeless. Examining the first of these issues it is hard to state with any degree of confidence how this figure has increased from examining State information sources. Local Authority estimates of the number of homeless conducted on behalf of the Department of Environment, as required by the 1988 Housing Act have been widely criticised (O'Sullivan, 1992; 1994; 1996; Leonard 1992). O'Sullivan (1996: 48) cogently states that assessments were 'crude, inaccurate and pretty well meaningless'. The Department of Environment's figures are detailed in Figure 1.

Figure 1 Department of Environment Assessments of Homelessness 1989-1999

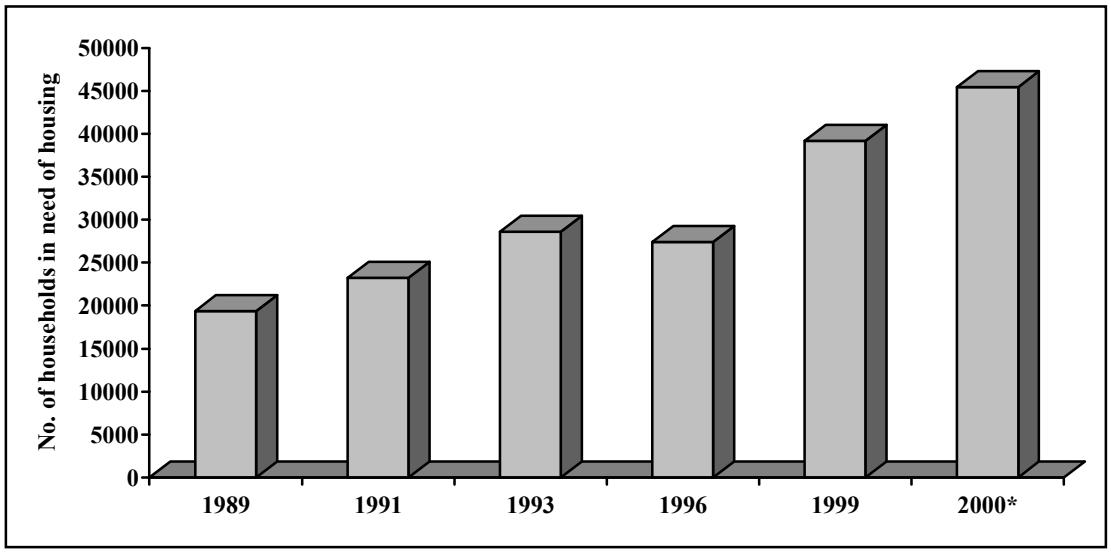


Although these figures would seem to indicate a sudden and dramatic growth in the number of homeless from 1996 to 1999, no real comparisons can be made due to methodological differences. Particular criticisms were made by Leonard (1994) concerning the poor methodology adopted in the assessments of homelessness, which no doubt greatly influenced the revised methodology adopted by the Homeless Initiative in the Eastern Health Board region for the 1999 assessment. The 1999 assessment of homelessness in the EHB region, conducted by the Economic & Social Research Institute (ESRI) involved widespread consultation with, as well as the involvement of, the vast majority of voluntary organisations working with the homeless in that region. In addition the adoption of a unique personal identifier for each case recorded (consisting of date of birth, initials and gender), as well as training and consultation sessions for staff in voluntary organisations, improved the quality and precision of the information recorded.

Although this improved methodology is to be welcomed and ideally continued in future assessments, it makes any analysis of trends to date invalid. It is unfortunate that although the local authorities have only assessed homelessness once every two or three years since the 1988 Housing Act, and even then have only taken a brief snap shot to quantify the picture, it has taken more than a decade to adequately achieve this, and even then only in the EHB region. This assessment still measures stock, rather than flow and given the absence of any information on the needs, strengths, views and preferences of the individuals involved, it remains a rather crude and sterile measure. This is not to deny the difficulties involved in actually counting homeless populations, which are well known (Schlay & Rossi, 1992; Collins & McKeown, 1992). However it is hard to imagine that the highly political nature of the subject has not lessened commitment to accurately measuring the extent of homelessness in the past, and may still inhibit an adequate count of the flow of the homeless, which will inevitably produce a much higher count (Fahey & Watson, 1995).

However despite this uncertainty there is little doubt that homelessness has increased in recent years. Recent assessments conducted in Galway and Cork confirms the disturbing picture elsewhere in the country (MacNeela, 1999). In the absence of accurate state statistics it is necessary to turn to alternative information sources to try and chart the growth in the number of homeless. Focus Ireland's own database details its contacts with individuals from 1985 onwards. Although these records no doubt also reflect substantial growth of the services offered by the organisation, there can be little doubt over the increase from substantially under 1000 in 1985 to approximately 5000 in 1999. Alternatively one can examine the Department of the Environment's Assessments of housing need to try and gauge the extent of the growing housing problem. These counts are detailed in Figure 2.

Figure 2 Department of the Environment Assessments of Housing Need 1989-1999



* Based on a Focus Ireland survey of all County Council and Corporation Housing Waiting lists in November 2000, this figure may include households, who after assessment will be deemed unsuitable for local authority housing.

However it should be noted that once again care must be taken in their interpretation. The Department of the Environment effectively minimise the actual figures they report by removing a considerable number of individuals from the list who they deem to be '*considered suitable for other housing measures'* (Department of the Environment, 1999: 1). The numbers involved are by no means small and should not be overlooked. In 1999 the number of households excluded on this basis was 6402, while in 1996 it was 6047. This exclusion is bizarre in a situation where *the other housing measures* are predominantly either voluntary sector housing, an industry still in its infancy in Ireland, or entry into the declining and increasingly prohibitively expensive private rented sector via the SWA rent supplement. These figures are also undoubted underestimates of Housing Need given that many single people do not apply to Local Authorities for housing because their chances of ever being housed by them are so slight. It should be noted that that at least one Local Authority levies a charge on individuals registering for housing. This must surely be a deterrent, particularly to single people, who can reasonably have little expectation of ever being placed.

The second aspect to the growing homelessness problem is that of increasing duration of homelessness. Again information on this issue is far from complete. However analysis conducted by Focus Ireland of households placed in emergency B&B accommodation in the Dublin Corporation area in 1993 found that the average length of stay was 16 nights (Moore, 1994). Provisional analyses conducted of similar placements for 1999 also conducted by Focus Ireland reveals an average placement period of 81 nights (Houghton & Hickey, 2000).

A number of research projects conducted recently in Ireland have detailed the length of time individuals have currently been homeless. Corr's (1999) examination of 169 male hostel dwellers reveals that almost half (49.7 per cent) had been homeless for more than

one year. The Cox & Lawless (1999) study of drug using homeless individuals records almost a quarter (24 per cent) had been homeless for more than a year. The increase in the duration of homelessness is an issue of particular concern. As will be discussed below in more detail, the negative effects of homelessness on both physical and mental health are both dramatic and worrying.

It should be noted that Ireland is not alone in experiencing a dramatic increase in the number of homeless. This development is an international phenomenon that has been widely reported in both the UK and the USA. From the late 1970s and early 1980s onwards there has been an increase in homelessness and inequality throughout almost all Western economies.

2.2 Pathways to Homelessness

The pathways to homelessness provide some insight into the needs of homeless people. Eleven pathways to homelessness have been identified by Timms & Balázs (1997) in a recent review. These are:

- unemployment;
- problem drinking among middle aged men;
- drug misuse among teenagers;
- lack of low rent housing;
- marital break up;
- clashes with family or friends;
- leaving local authority care;
- leaving the armed forces;
- leaving prison;
- episodes of mental illness; and
- children of homeless families.

Homeless people therefore have the same needs as the rest of the population. However in addition to access to accommodation, many homeless people face additional challenges. While acknowledging the need for more accommodation, it is important to appreciate that a proportion of the homeless population require more than just 'bricks & mortar'. As indicated above addiction problems can present a serious issue, as can poverty and the need to gain employment. Relationship difficulties and marital conflict can often leave its own trauma, which can require help in overcoming. Mental and physical health problems can require particular specialist support and intervention.

2.3 Barriers to Access for Homeless People

Perhaps the most significant barrier to accessing health and medical services is the absence or restricted provision of such services. However a substantial body of literature has developed over the last ten or fifteen years examining reasons why homeless individuals have difficulty in accessing existing health and medical services. This literature is discussed here in an effort to develop principles of barriers to access homeless people face in accessing all types of services, rather than just health or medical services. The development of such general principles can act as a guide that can be used to help appraise the accessibility of all services to homeless individuals.

Individual authors have identified different barriers to access, although these tend to 'cluster' around a number of key themes. The first regularly cited barrier is finance, with homeless individuals unable to afford consultation, therapeutic and medication costs (Wood & Valdez, 1991; Cousineau, 1997; Gillis & Singer, 1997; Van Hook & Ford, 1998).

The second commonly cited barrier to access is that of transportation and distance (Wood & Valdez, 1991; Cousineau, 1997; Van Hook & Ford, 1998). Homeless individuals can find it difficult to access services in different geographical areas due to a number of problems, including low rates of car ownership and difficulties using complicated networks of public transport.

The third frequently cited barrier to access was a lack of knowledge of where to go to access services (Wood & Valdez, 1991; Cousineau; 1997). Homeless individuals may have little or no knowledge of what services are available, or when faced with a myriad of differing specialist services may be unsure which is the most appropriate to access.

The fourth routinely cited barrier to access is that of waiting times (Wood & Valdez, 1991; Cousineau, 1997; Van Hook & Ford, 1998). There are two elements to this problem. Primarily there is the barrier of extensive time spent in waiting rooms waiting for services. As Wright & Joyner (1997:210) state '*Perhaps the distinguishing feature of the daily existence of homeless people is that they are required to stand in line for practically everything*'. Such long periods of waiting are a strong disincentive to accessing services. Secondly there is the issue of extended waits for appointments with health and medical professionals. Such delays can act to minimise the importance of referrals to individuals, or in the disorganised lives of a proportion of homeless people effectively block access. As Wright & Joyner (1997:210) state '*"Come back next Thursday" is a sensible request only if the concept of "Thursday" itself has meaning; among many homeless people, and especially among the mentally ill and substance abusive, it does not*'.

On a related issue a barrier to access often noted in the literature is centred on personal issues. A number of obstacles to access have been noted in relation to this issue. These include personal disorganisation and disassociation. Van Hook & Ford (1998) state that the homeless mentally ill *'are likely to be disaffiliated from social services and too disorganised to gain access to the mental health system*'. Ramsden, Nyiri, Bridgewater & El-Kabir (1989:373) identify particular problems, stating '*Some found waiting rooms and appointment systems difficult to cope with*'.

Another often noted barrier of access to health and medical services for homeless people is their mobility (Timms & Balázs, 1997). Continuity of care is often impossible due to the transient lifestyle adopted by many homeless people. This can cause particular difficulties in relation to issues such as referrals (Wood et al., 1997). A related aspect of health care which can act as a sticking point in accessing an effective service can include the practice, sometimes adopted by psychiatric and other health services, of treating the

homeless on the basis of a rota ('no fixed abode rota'), rather than allocating individual cases to health professionals (Timms & Balázs, 1997).

An additional barrier to effective healthcare identified in the literature relates to communication difficulties (Timms & Balázs, 1997). There are a number of specific areas in which language problems present. Perhaps the most obvious is the barrier of language differences (Power *et al*., 1999). This has been noted particularly in relation to members of ethnic minority groups and asylum seekers and refugees. Another obvious problem is that of literacy, which can be a problem among some sections of the homeless population. This has been noted particularly in relation to health promotion literature, but the wider implications are obvious (Power *et al*., 1999). Other communication difficulties can include simple class and educational differences in the use of elaborated or restricted language. However communication difficulties can be caused or exacerbated by alienation and stereotyping, which can affect both health professionals, as well as people who are homeless. As Timms & Balázs (1997:537) state that given both the statutory and voluntary sectors' inability to change their circumstances '*It is not surprising that homeless people are often suspicious and distrustful of services that like to see themselves as caring and helping'*. The frequent disappointment felt by people who are homeless when dealing with services, particularly statutory services, in turn affects staff in these organisations. Timms & Balázs (1997:537) argue that '*Their predicament makes demands that these agencies cannot meet, often provoking inadequate or even punitive responses ... The difficulty in treating homeless people can produce a therapeutic nihilism that may not only prevent professionals from doing what they can but may even serve as a justification for neglect'*. The Standing Conference On Public Health comment on this issue stating that the difficulties homeless people experience are seen as intrinsic to the person, thus they become a '*problem patient'* (1994:28). Holohan touches on this topic in his study of barriers to service utilisation in Ireland, in reporting a comment made by a homeless individual who described being looked down on by *'unhelpful and uninformative staff'* (Holohan, 1997:18).

The '*competing priorities'* hypothesis has also been put forward to explain why homeless individuals have difficulty accessing health and medical services (Gelberg et al., 1997; Elvy, 1985; Andrade, 1988; Koegel & Gelberg, 1992; Stark, 1992). This hypothesis suggests that the struggle to satisfy primary needs, such as food, shelter and safety, takes precedence over less immediate health concerns.

The final barriers to effective healthcare identified in the literature include the practice of banning some homeless people from particular health and medical services and a lack of appreciation of the constraints of homelessness (Van Hook & Ford, 1998). This could include the practice of prescribing bed rest, or other inappropriate and unfeasible recommendations.

Holohan's (1997) study of the homeless in Dublin solicited the views of homeless people themselves on barriers to access. His responses fall into four general categories. The first barrier he identified is covered in the review above and is not surprisingly the financial barrier. The second barrier he identified is discussed above and relates to what homeless

people identified as the 'unwillingness on the part of staff' to give homeless people the information they felt they needed (Holohan, 1997). However Holohan identified two additional perceived barriers to service access in Dublin. The first of these was the fear and intimidation that homeless users of health services experienced. The second barrier was a perception among homeless people of the preferential treatment being given to refugees and asylum seekers.

3.0 Methodology

Three teams were involved in the identification of the research and in the collection of information; the Crisis Team, the Outreach team and the Extension. The Crisis Team operates in an open-access coffee shop in Dublin city centre and provides accommodation advice and support. The Outreach Team is a group of street workers who routinely provide support and social contact to those sleeping rough in Dublin city centre. The Extension is a project designed specifically for 18-25 year olds and provides support and recreational/educational activities in a safe, structured environment in central Dublin (as well as laundry & washing facilities). All three teams work from a developmental approach, attempting to aid individuals to link in to relevant services to move through and beyond homelessness.

3.1 Participants

Focus Ireland's Crisis, Outreach and Extension teams were asked to identify potential participants in this study. To be included in the study participants had to:

- be aged 18 years of age or over;
- have been homeless for six months or more; and
- currently have a Focus Ireland key worker.

In light of the different needs and circumstances involved, this study does not include individuals seeking asylum. The target sample size was 30 adults.

3.2 Instruments

The study involved two distinct elements. The first part consisted of an interviewer-administered questionnaire that focussed on current circumstances and in addition involved a retrospective examination of service use. Completing this questionnaire took approximately 45 minutes. This questionnaire contained a number of standard psychometric instruments. These included the Short Form 12 health questionnaire, the CAGE questionnaire, and an assessment of alcohol and drug use. In addition other sections examined accommodation histories, demographic details as well as an examination of, and views on, services used in the previous 3 months.

The Short Form 12 questionnaire, usually known as the SF-12, is produced by the Medical Outcomes Trust in the US and is a 12-item measure, yielding overall physical and mental health scores, as well as a composite total score. The questionnaire has been found to be both reliable and valid, and has been used extensively elsewhere (Jenkinson & Layte, 1997; Jenkinson et al., 1997). In addition Irish norms for this measure have recently been produced, standardised on the US population and will be used for comparison purposes in this project (Layte, 1999).

The CAGE questionnaire is a short four-item measure designed for General Practitioners to evaluate alcohol dependence. This measure has been used extensively and has formed a crucial element of other research projects in Ireland (Jackson, 1997). A standard method of investigating illicit drug use was included. This methodology was adopted from the Irish *National Health and Lifestyle Survey* (Kelleher et al., 1999). This format asks individuals whether they have ever taken particular drugs and whether they have taken them in the last month. This information yields data on lifetime usage and current usage (usage in the last month is a generally accepted measure of ongoing use).

The follow-up element of the study was essentially a free response sheet for each participant, sent to team leaders to distribute to key workers every week. Each sheet included the participant's name and details of the period under investigation. Consultation and training sessions were held with liaison personnel in each team to discuss the proposed format of the follow-on sheets. In view of the often-changing circumstances of the homeless population, it was agreed that key workers would profile emerging issues, changing circumstances, accommodation moves and service use as necessary, rather than adopting a fixed format.

3.3 Procedure

Support staff in Focus Ireland services conducted interviewer-administered questionnaires. In line with findings of previous research (Shanks, 1981) it was felt that support workers who already had a rapport with the study's participants should complete the research instrument, rather than an impersonal 'research worker' (Ramsden et al., 1989).

The second element to this project involved prospectively following the identified group of participants over a three-month period. Attrition rates in longitudinal studies of any population are always a problem. Attrition rates in such studies of homeless populations are routinely relatively high, and follow up of this transient population has always been acknowledged to be a difficult task. Conover et al. (1997: 92) suggest that it is as a result of these problems that *'until the past decade, follow-up studies among inner-city elusive populations, such as the homeless mentally ill, who are often highly mobile, transient, or otherwise difficult to reach, were rare'*.

Methods for improving participation and follow-up with the homeless population have included interviewers learning about the ecology of participants, empathising with participants, and each interviewer having been allocated a caseload and developing a relationship with participants (Conover et al., 1997). Empathising with participants is what Koegel (1992) terms adopting an '*insider's perspective'*. The research literature identifies the obvious importance of interviewers being careful to guard the confidentiality of the participant and to be non-judgemental. As Conover et al. (1997) stress, trust and continuity are vital elements of a successful follow-up. Harway (1984) highlights the importance of the personal touch in such research.

In line with Conover et al.s' (1997: 97) and Wright, Allen & Devines' (1995) suggestion the interviewers attempted to be '*flexible and creative'* in their efforts to locate and

interview participants. Therefore the interviews and follow-ups were conducted in a variety of locations including cafes, fast food shops, Focus Ireland premises and on the streets. Traditional follow-up methods such as scheduled appointments, telephone and mail notification and home visitation are routine methodologies with little relevance to the highly chaotic lives led by some homeless people. However as Conover et al (1997) state the location of an office or place of work (such as Focus Ireland's *Coffee Shop* and *Extension*) can be a constant in otherwise highly disorganised and chaotic lives. Therefore, and this applies particularly to the Extension and Crisis teams, the participants in the study often came to the interviewer, rather than visa versa.

4.0 Main Findings

The main findings of the research are discussed in two separate sub-sections; the first section deals with the findings from the profiling of a small group of Focus Ireland customers, the second describes the findings of the 3-month long tracking research.

Seventy-one individuals meeting the criteria for inclusion in this research project were identified from their records by the three Focus Ireland teams involved. Twenty-two of these people were not in contact with Focus Ireland for the duration of the study. A total of 49 people were therefore approached to take part in the project. The main questionnaire survey was completed with 25 individuals, yielding a response rate of 51 per cent. However the weekly follow-on sheets for the three-month longitudinal element of this study were recorded for 44 out of the 49 potential participants.

The response rate in this study is lower than would have been hoped. However, below optimum response rates are a feature of research with homeless populations. This response rate is not dramatically different from that achieved in other research studies with the homeless (Holohan, 1997; Wright & Devine, 1995; Link et al., 1994; & Victor, 1992). Many research projects studying homeless populations simply do not record response rates (George et al., 1991; Gelberg & Linn, 1989), while others can only estimate actual response rates (Cox & Lawless, 1999). Response rates as low as 34 per cent have been recorded with homeless populations in Ireland (Moore, 1994). Therefore considering the chaotic lifestyles of many homeless people, particularly the long-term homeless, the response rate may be deemed acceptable. Marshall et al. (1994) discuss the mechanisms through which some homeless people lose contact with 'caring agencies'.

To appreciate fully the low response rate achieved it is important to understand the context and situation in which this research was conducted. To illustrate this a few examples are included which should illuminate some of the difficulties encountered:

One potential interviewee who for the sake of confidentiality we will call John contacted the Outreach Team in the second week of the study on his way to his probation officer. Due to this appointment he could not complete the questionnaire, but stated that he would return to do so. Subsequently there was no contact with John for two months, when word was received that he was in St. Pats prison on remand.

Another potential interviewee who we shall call David was met on the street while begging. At this meeting David stated that he would call into the coffee shop to complete the questionnaire. David did not call in and was subsequently met begging on the streets. However on these occasions he was using drugs extensively and contacts were brief. When encountered on a subsequent occasion some weeks later he had been involved in a dispute with a group and was being chased by them. Obviously at this point he was not engaged. In a final meeting during the research period David was too physically unwell to participate.

Another potential interviewee who we shall call Michael was met in the Coffee Shop, at which point he stated that he would fill in the questionnaire at a later date. He did not fill it in when met subsequently and when met again was being 'moved on' by the gardai. Michael was met again on only three subsequent occasions during the research period. Part of his absence was due to some time spent in prison. At the following meetings he was very low and hard to engage, while at the final meeting he refused to engage at all.

Another potential interviewee who we shall call Gemma, was only in contact with Focus Ireland staff twice during the three month study period. On the first occasion she was sleeping rough and too 'stoned' to talk. During the second meeting she was still using drugs and was in extremely low spirits. All she could focus on in this encounter was trying to return home to her family.

Other reasons that hindered data collection included instances when potential interviewees were being chased by other people, or did not want to interrupt their begging to complete the questionnaire.

The follow-up period consisted of 13 weeks, over the months April, May and June. Participants in the follow-up study were in contact with the three teams involved in the study at least once or more per week for an average of 8 of the 13 weeks. This level of regular contact allowed careful monitoring to continue.

The Crisis team completed the majority of the questionnaires (15, 60 per cent), Outreach completed 7 (28 per cent), while the Extension team completed 3 questionnaires (12 per cent).

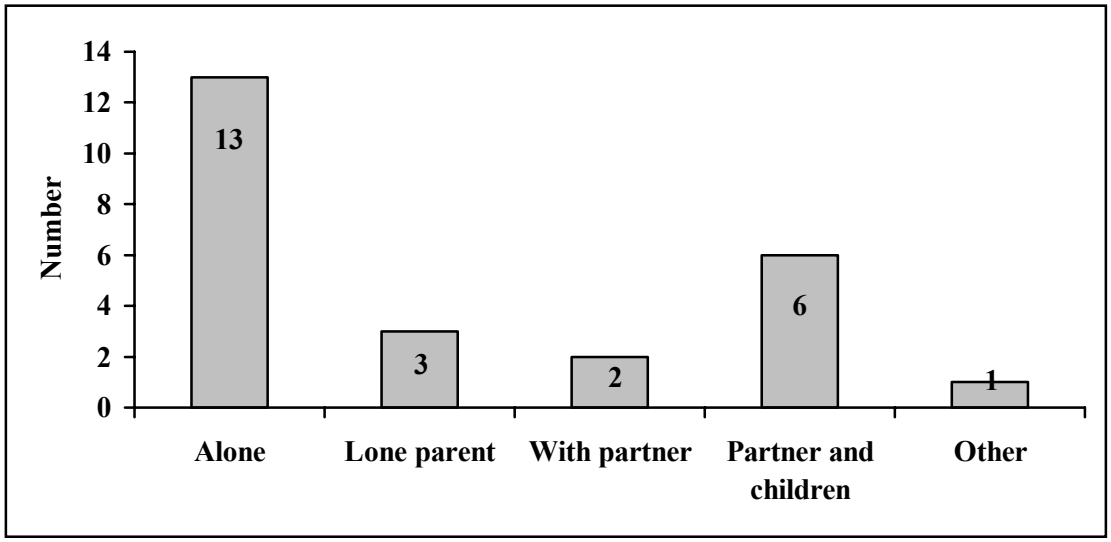
4.1 Main Findings from the Profiling Survey

The following sections outline the main findings in relation to the 25 respondents who participated in the profiling exercise.

4.1.1 Participant Demographics

Slightly more men (13) participated in the research than women (12). The average age of participants was 25.5 years. Examining family status and composition, 15 participants were single, while 9 were either married or cohabiting. One participant was either separated, divorced or widowed.

Figure 3 Family Status of Participants



Three participants had one child, two had two children, five had three children and one had four. Almost a third of participants (8) reported that they had children in care or being cared for elsewhere.

Figure 4 details the educational histories and qualifications of the sample in this study. It should be noted that 10 respondents did progress to the examination stage of their formal education.

Figure 4 Educational History of Respondents

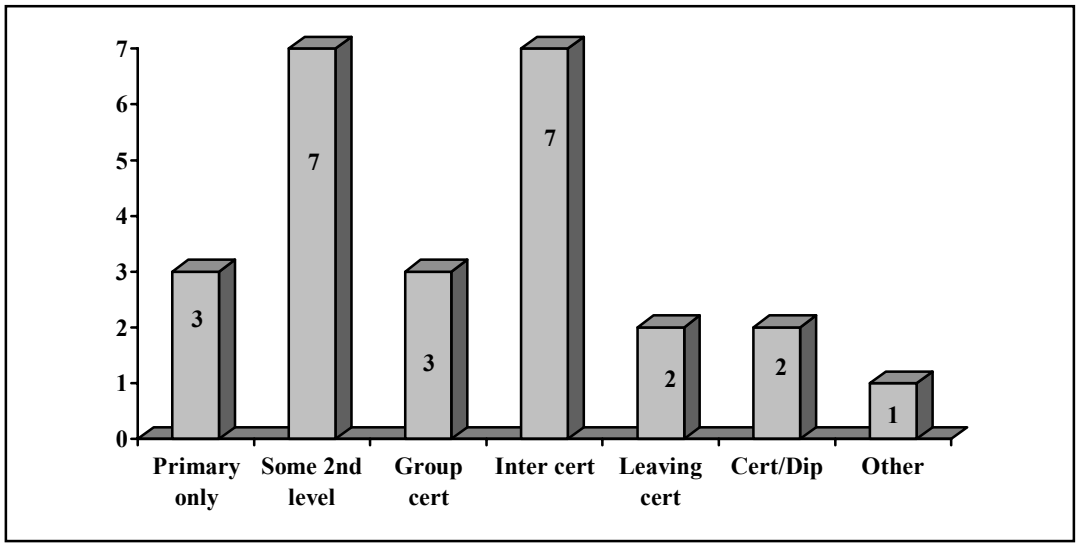
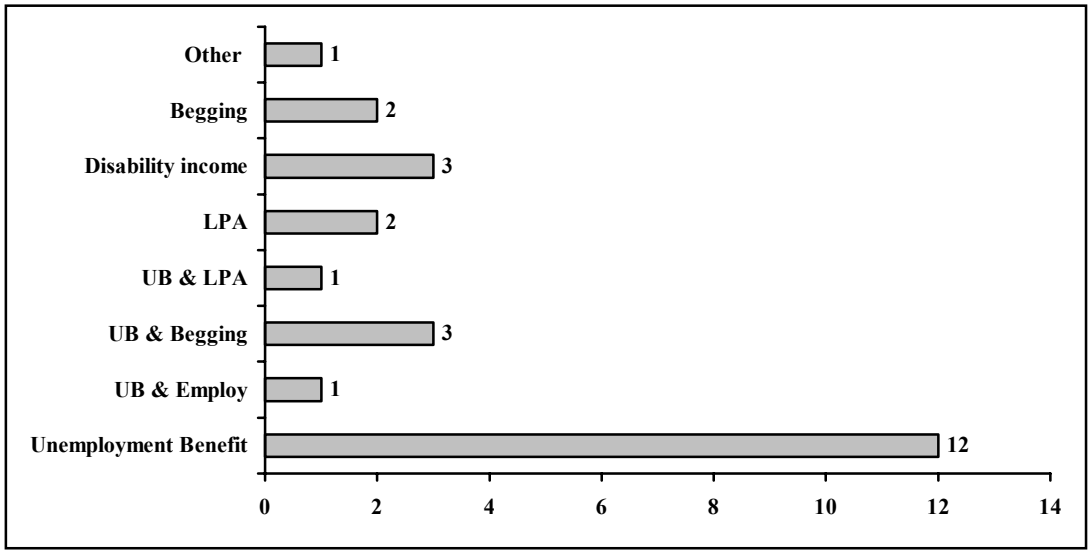


Figure 5 details another aspect of deprivation, namely income. It will be noted that only one respondent reported that they were employed. The high proportion on disability income (3), and the number indicating that begging is their only source of income are issues of particular concern.

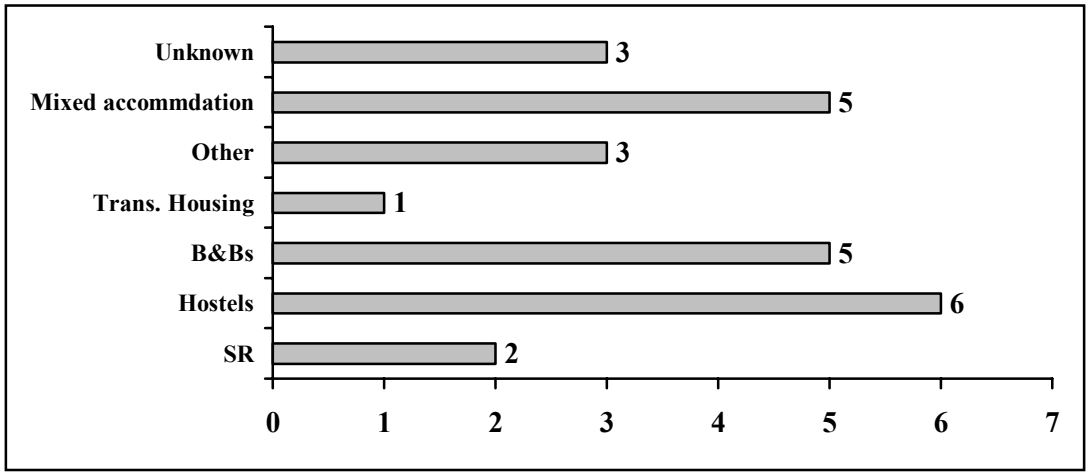
Figure 5 Sources of Household Income



4.1.2 Current Accommodation

In the seven days prior to the completion of the questionnaire over three-quarters (17) had stayed in one accommodation type (see Figure 6).

Figure 6 Accommodation Type of Participants Over The Previous 7 Days



Three individuals had stayed in two places, while one person (4 per cent) had stayed in three places and one had stayed in four (missing data- 3, 12 per cent; see Table 1).

Table 1.
Accommodation Usage of the Five Individuals Using Mixed Accommodation Types Over the Previous 7 Days (no. of nights)

Profile	Sleeping Rough	Hostel	With Friends	Prison
Female, aged 24	1	6	------	------
Female, aged 19	6	------	1	------
Male, aged 19	6	------	------	1
Male, aged 24	1	2	4	------
Male, aged 18	3	1	2	1

4.1.3 Duration of Homelessness & Repeated Homelessness

Six respondents reported that they were currently experiencing their first episode of homelessness. The remaining 19 reported that this was not their first out of home episode. Respondents reported episodes of homelessness stretching back over 16 years. The mean average length of time elapsed since individuals had first been homeless was approaching six years (approx. 307 weeks; median 265 weeks). Individuals reported currently being homeless for a mean average of over one and a half years (84 weeks; median 44 weeks). However one respondent stated that their current episode of homelessness had lasted in excess of eight years (417 weeks).

4.1.4 Housing Histories- Housing Type

Prior to becoming homeless, the majority of respondents (11) had lived in local authority housing. However 5 had lived in private rented sector accommodation, with almost the same number having lived in owner occupied accommodation (4). One respondent had lived in a house purchased under the shared ownership scheme, two others had previously been in care, while the remaining three respondents had lived in other types of accommodation.

4.1.5 Housing Histories- Family Set-up

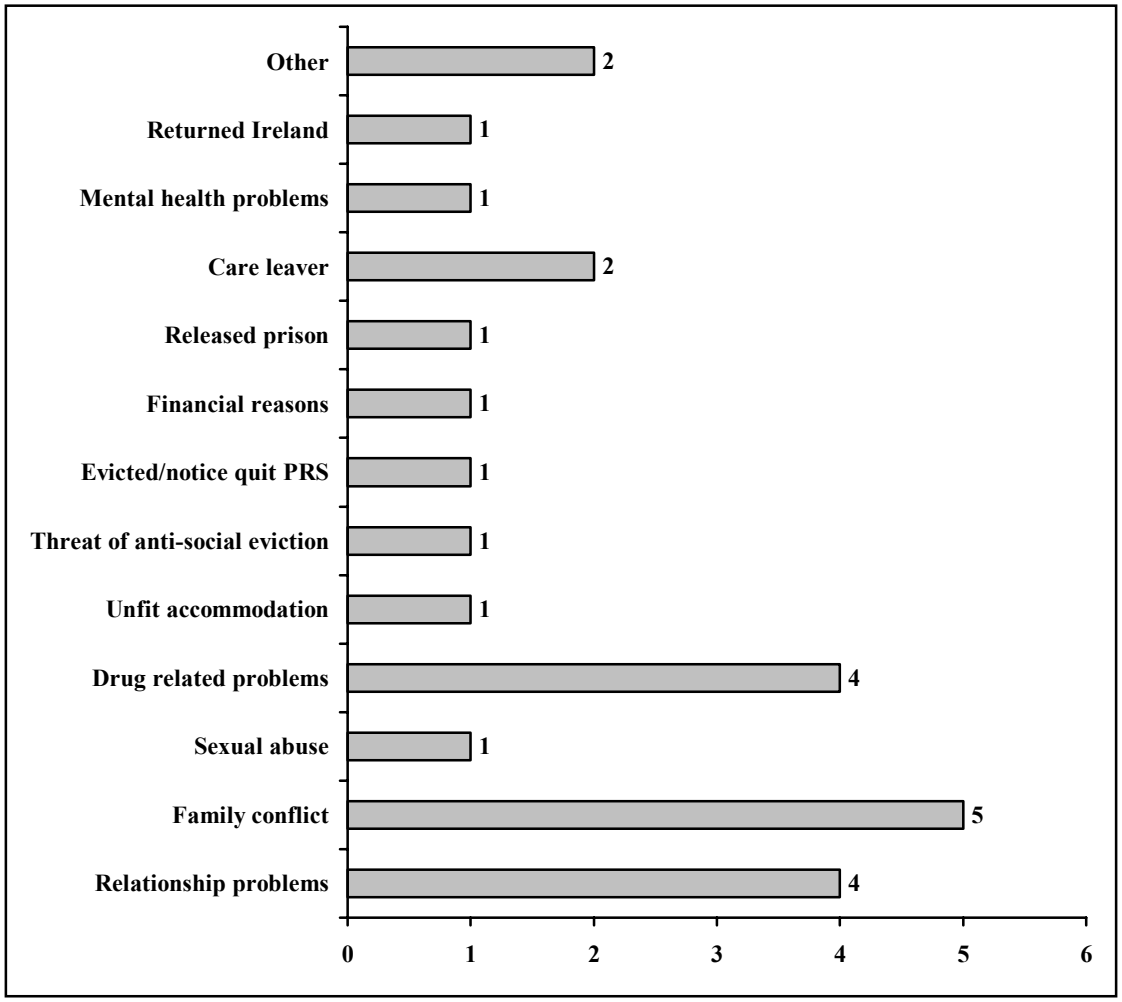
Almost half (11) of the respondents lived with their family of origin before becoming homeless, four had lived with friends or relatives, while the same number lived on their own as a parent. Two had lived alone, while the same number had lived with their partner. As mentioned above two respondents had lived in care until becoming homeless.

4.1.6 Causes of homelessness

Respondents were asked to identify the primary cause of their homelessness (one cause) as well as identifying any number of secondary causes. Primary reasons or factors were identified as the most significant reasons for their homelessness and often indicated a level of need beyond that of 'bricks and mortar'. The inclusion of secondary reasons/factors allowed the household to identify more than one factor for their homelessness thus recognising that in many cases there is no one factor or simple reason for homelessness.

However, it is important that these factors should not be interpreted as definitive 'causes' of homelessness for a number of reasons. Firstly, as Fahey and Watson have pointed out the personal experiences of out-of-home households contribute to homelessness in a more complex economic and housing need environment (1995). Secondly, people when asked about precipitating factors for their homelessness tend to consider the triggers of the homelessness rather than the underlying factor or cause. Despite these caveats the reasons or factors as identified by the respondents themselves are important in assessing the level of need and the type of interventions required to assist homeless individuals. The pathways into homelessness are complex and are often made up of many factors including housing need, personal issues, economic disadvantage and social isolation.

Figure 7 Primary Reason for Homelessness



As can be seen from Figure 7, family conflict (5) and relationship problems (4) constitute the most significant contribution leading to homelessness. This finding of homelessness resulting from relationship breakdown in over one third of cases (9) is consistent with other research conducted in Ireland. Fahey & Watsons' (1995) authoritative study of social housing need reported that this was the cause of homelessness in 40 per cent of cases they examined. The significance of drug related problems must also be acknowledged. Four (16 per cent) respondents openly cited this as the principal cause of their homelessness. This figure is double that recorded in the Fahey & Watson report. This may be a measurement artefact, but probably reflects the increasing problem of drug use in Dublin. As mentioned above the problem of addiction and homelessness is such that in the last year two research reports, both based on Dublin populations have been produced (see Cox & Lawless, 1999 & Costello & Howley, 1999).

It is not surprising that two of the participants (8 per cent) had left state residential care prior to becoming homeless. This has been a common finding in both the international and Irish literature. For example, O'Sullivan (1996) reports on an unpublished study of youth homelessness conducted by the Eastern Health Board (1987), which found that

22.7 per cent of those in contact with their services had formerly been in residential care. A study of youth homelessness conducted jointly by Focus Point and the EHB (1989) the following year examined five areas in Dublin over a 54-day period and found that 38 per cent of homeless youths had previously been in long-term care. Another study conducted by the Mid-Western Health Board (Keane and Crowley, 1990) focussing on youth homelessness in Limerick reported a higher figure of 29 per cent. An EHB study conducted in conjunction with voluntary organisations in 1993 found that 40 per cent of homeless children in contact with their services had formerly been in residential care. More recently the Southern Health Board's Review of Adequacy of Child Care and Family Support Services (1996) found that 35 per cent of young people out-of-home were previously in care. Kelleher Associates (1998) have also reported on this issue in a recent Focus Ireland report. This research, conducted over one week examined the circumstances of young people presenting to the Crisis Intervention Service of the Eastern Health Board ('out-of-hours'). Forty per cent of young people using the Out-Of Hours service had previously been in state care.

It will probably come as no surprise to note that the remaining causes of homeless are all sadly familiar. For example one person became homeless primarily as a result of sexual abuse, while another 5 cited it as a secondary reason (see Table 5). Patterns of violence against homeless individuals often begin in childhood (Wright & Devine, 1997). Biographies of homeless people frequently cite instances of sexual, physical and emotional abuse (Burroughs et al., 1990; Susser, Lin, Conover & Struening, 1991).

In addition one respondent was released from prison and became homeless. Fahey & Watson (1995) record that 5 per cent of their sample were released from prison to become homeless. Other primary reasons include financial reasons (1), unfit accommodation (1), mental health problems (1, 4 per cent), as well as return migration to Ireland (1, 4 per cent). Fahey & Watson recorded that 5 per cent of their sample had become homeless as a result of unfit accommodation, and that 7 per cent as a result of psychiatric problems.

The remaining primary reasons for homelessness may give insights into other aspects of contemporary Ireland. One respondent was evicted or given notice to quit the private rented sector. The private rented sector has been slowly contracting in Ireland in recent years, particularly as house prices have experienced significant growth. This has been termed the 'gentrification' of former areas once reputed as areas of cheap flats and bed-sits (such as the inner city or Rathmines; O'Morain, 1999). Another respondent had become homeless as a result of being threatened with anti-social eviction by a Local Authority. This may sound strange given that the respondent became homeless anyway. However it is important to note that tenants formally evicted under such legislation are black listed and may not be re-housed by the Local Authority in the future. Tenants opt to leave before such an eviction in order to stand a better chance of being re-housed at a future point in time. The use of this threat of 'anti-social eviction' is an issue Focus Ireland staff on the ground have been encountering over the past couple of years, since the introduction of the Housing (Miscellaneous Provisions) Act 1997. It is an issue of concern as it is obviously open to abuse and it does not seem to be routinely formally

recorded anywhere. Citing a paper from Dublin Corporation to the Strategic Policy Committee, Cox & Lawless (1999:63) report that there were 44 evictions and 200 house repossessions related to anti-social behaviour in the Dublin Corporation Area in 1998.

Examination of Table 2 reveals the secondary reasons respondents cited as causes of their homelessness. Of note and not discussed above is the importance of domestic violence (4).

Table 2 Secondary Reasons Cited for Homelessness

Secondary Reason Cited	Number
Relationship problems	2
Family conflict	7
Domestic violence/physical abuse	4
Sexual abuse	5
Drug related problems	3
Alcohol related problems	2
Unfit accommodation	5
Overcrowded accommodation	6
Evicted/ given notice to quit private rented sector accommodation	2
Barring Order	1
Financial reasons	2
Released from prison	3
Left residential care	1
Mental health problems	3
Involuntary sharing	3
Returned to Ireland	1
Tenure insecure	2
Other	2

An American study conducted by Wright, Devine & Joyner's (1993) examined substance-abusive homeless men and women in New Orleans and revealed the extreme levels of interpersonal violence some homeless women have endured. This study found that '*the average woman in the sample had been robbed 3 times in her life, assaulted or beaten up 14 times, raped 5 times, and shot at once'* (quoted in Wright & Joyner, 1997: 213). While this study may appear too extreme to be of relevance in Ireland, it should be remembered that this is probably only further down a continuum of abuse some homeless women in this study have already suffered. It must be remembered that domestic violence from '*abusive mates'* is a leading factor for homelessness among women (Wright & Joyner, 1997: 214; Browne, 1993). In this respect research in both the UK and Ireland would support the importance of domestic violence as a pathway for women leading to homelessness (Kennedy, 1984).

As can be seen from Table 2, other notable secondary causes include family conflict (7), as well as unfit (5) and overcrowded (6) accommodation.

4.1.6 Numbers Seeking Long-term Accommodation & Housing Lists

It is sometimes suggested that many of the long-term homeless do not actually want long-term accommodation. However the overwhelming number of respondents in this survey (20) stated that they were seeking long-term accommodation. Less than one fifth of respondents (4) stated that they were not presently seeking long-term accommodation (one non-respondent).

It will come as no surprise therefore that 21 respondents were on at least one local authority housing list. Fifteen of the respondents were only on Dublin Corporation's list, while one respondent was only on South Dublin County Council's list. A further 4 were on both lists mentioned above, while one person was on the list of a non-Dublin Local Authority.

4.1.7 Mental Health & Physical Health

As discussed above the SF-12 questionnaire was used to examine the physical and mental health of the study participants. The SF-12 yields two scores, the physical component summary scale (the PCS-12) and the mental component summary score (the MCS-12). As the average age of participants in the study was 25.7 years, most of the analysis was conducted comparing the scores from this study with the Irish norms for the age group 16-29 years.

Results from this questionnaire were recorded for all but one study participant, who declined to take part in this element of the study. Therefore the sample size in this element of the research was 24. The mean average physical health score of the participants was 43.59 (SD = 12.09). The Irish norm for the age group 16-29 on the PCS-12 was higher (i.e. more healthy) at 48.08. However the difference although approaching significance was not statistically different (the difference was no more than might be expected as a result of random fluctuations). The participants in this study had a mean average mental health score (MCS-12) of 35.45 (SD= 7.71). This score is significantly lower ($p<.01$) than the Irish norm in the 16-29 age group which is 41.13.

The mental health of the population examined in this study is therefore significantly worse (in statistical terms) than the general Irish population of a comparable age (16-29 years) as assessed by the SF-12. The physical health of the group however is not statistically different than that of the general population of a comparable age.

Despite the overall SF-12 physical health score, a number of respondents did report serious illnesses. Tuberculosis and Hepatitis are infectious diseases and common ailments among homeless populations, and this sample was no exception. Four respondents reported having Hepatitis, while one respondent reported having Tuberculosis. The rate of Hepatitis reported is considerably higher than the 4.7% recorded in Corr's (1999) analysis of homeless hostel dwelling men in Dublin city centre. The rate of Tuberculosis recorded here at 4 per cent is also higher than the 1.8 per cent recorded by Corr (1999) and the 2.5 per cent recorded by Holohan (1997). The crucial difference in these results compared with the population examined here, may be the fact that this study examined only those homeless for more than six months. Two respondents also reported suffering

from asthma, one from chest pain, while another had a pacemaker. One participant reported suffering from dermatitis, in addition to which another reported having a malignant tumour. One respondent had a learning disability and one respondent reported suffering from deafness.

The first item on the SF-12 measure asks respondents to rate their general health. The results indicate that 12 per cent of respondents (3) rated their health as excellent, 8 per cent (2) rated it as very good, while 16 per cent (4) thought that their health was good. However, the majority (13) felt that their health was fair and three thought their health was poor.

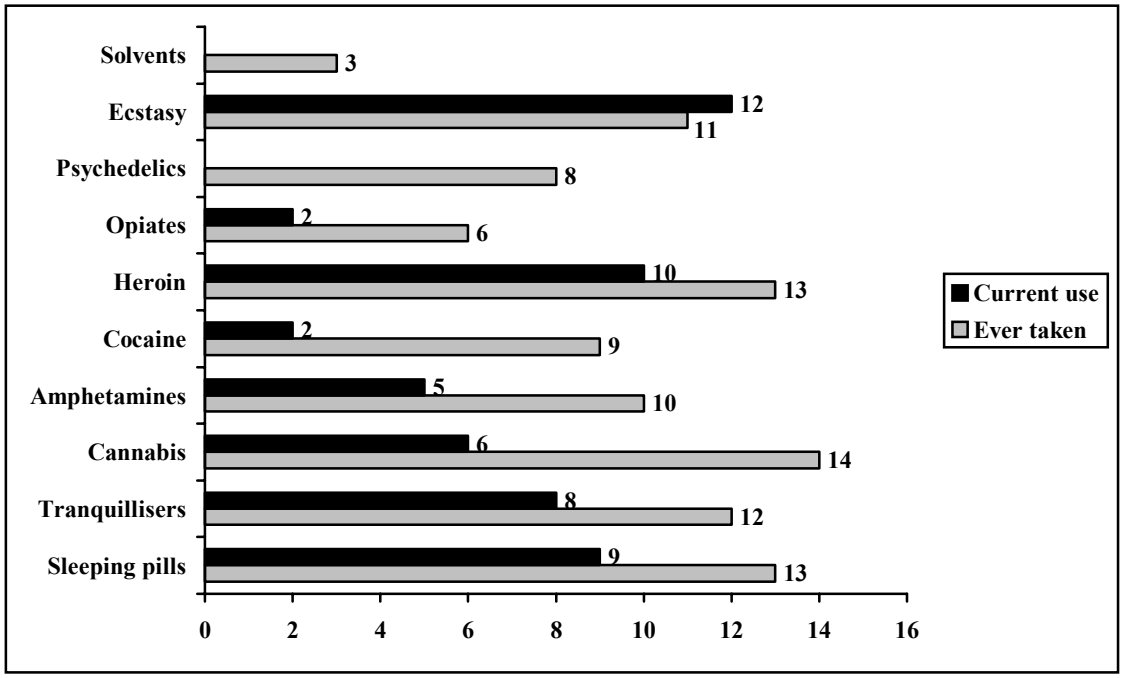
Turning in more detail to examine mental health, 9 respondents reported that they suffered from a psychiatric illness. Three respondents reported stress/anxiety problems, while one respondent reported suffering from paranoia, schizophrenia and depression. A total of 5 respondents reported depression, while one respondent reported suicidal ideation. Higher mortality rates among the homeless leading to drastically reduced average life expectancy from both natural and unnatural causes has been noted by Hibbs et al. (1994).

It is difficult to comment in detail on the mental health findings in detail. Estimates of the extent of mental health problems among the homeless population vary alarmingly. Cleary & Prizeman (1999) report that estimates of the prevalence of mental disorder among homeless people vary from 3% (Newton et al., 1994) to 91% (Bassuk et al., 1984). This range is even greater than the 70% difference reported in the earlier work of Coleman & Wilson (1991) who commented on estimates that varied from 20%-90%. Reported prevalence rates for the level of schizophrenia among hostel dwellers vary to an equal degree. This level of variation in reports is disconcerting. Some of the differences are no doubt due to differences of definition and measurement techniques, others may reflect differing populations, spatial or temporal differences. However such differences strengthen the need for the adoption of standardised assessment criteria, measurement tools and training to help clarify the situation.

4.1.7 Drug Misuse

An area of particular concern in relation to both mental and physical health among this study population is drug misuse. Seventeen respondents stated that they had ever misused drugs. The issue remains one of concern 16 respondents were currently misusing drugs. Figure 8 details the responses of participants to the ten different types of drugs listed in the questionnaire.

Figure 8 Prevalence of Lifetime & Current Drug Misuse



Lifetime prevalence as well as current use (within the last month) is detailed in this figure. Lifetime prevalence of misuse was highest for Cannabis (14), Heroin (13), and Sleeping Pills (13), which had all been used by over half of the study population. However an issue of more concern is the significant continuing abuse of class A drugs such as heroin, which is being used on an on-going basis by ten respondents (40 per cent). Approximately one-third of the sample population were currently misusing sleeping tablets (9) and/or tranquillisers (8).

However from a number of perspectives the issue of drug misuse is compounded by the common rate of poly-drug use among this population. The health implications of multiple drug use in particular are significant. Table 3 details lifetime poly-drug use, while Table 4 details the ongoing nature of this significant problem.

Table 3 Lifetime Poly-Drug Use

Number of Named Drugs Ever Used	Number of Respondents
None	8
One Drug	2
Two Drugs	2
Three Drugs	0
Four Drugs	0
Five Drugs	2
Six Drugs	5
Seven Drugs	0
Eight Drugs	2
Nine Drugs	3
Ten Drugs	1

Focussing on current poly-drug use we note that although 9 respondents are not taking any drugs, only 5 are currently misusing only one drug. Therefore almost half of the study population are not merely misusing drugs, but are misusing a potentially lethal cocktail of drugs. Respondents recorded using up to seven different drugs on an ongoing basis. A related serious issue is that of injecting drug use. Ten respondents in this survey reported that they had injected drugs at some time.

Table 4 Current Poly-Drug Use

Number of Named Drugs Currently Being Used	Number of Respondents
None	9
One Drug	5
Two Drugs	3
Three Drugs	4
Four Drugs	1
Five Drugs	1
Six Drugs	1
Seven Drugs	1

This is significantly higher than the 12 per cent recorded in the Feeney et al. (2000) study that asked the same question.

4.1.8 Alcohol Misuse

Although more than half (13) of the respondents reported that they did not currently drink alcohol, alcohol misuse is a problem among a significant segment of the sample population. Among those who drink the mean average weekly consumption is over 70 units (one unit is approximately half a pint of beer, one glass of wine or one measure of spirits). Holohan (1997) reported a weekly average of 49.8 units among those who drank alcohol in his sample. However the median average of this sample is just 21 units, and this reflects the effect a small number of very heavy drinkers can have on the mean. The Department of Health (1995) recommended limits for alcohol use are 21 units per week for men and 14 units per week for women. Adopting these guidelines 4 of the men in this sample and 3 of the women exceed the recommended guidelines on alcohol consumption. Thus overall 28 per cent (7) of the sample was consuming too much alcohol. This figure is very similar to that recorded by Holohan (1997) who stated that 29 per cent of all respondents in his survey drank over the recommended limits.

As discussed earlier, the CAGE questionnaire is a short 4-item measure designed to detect problem drinking. Two or more positive answers were considered to be CAGE positive indicating a problem, or dependent use of alcohol (Jackson, 1997). Using this cut-off, 5 respondents would appear to have an alcohol problem. A gender breakdown of this response reveals that 4 (31 per cent) men were CAGE positive, while only one woman (8 per cent) was CAGE positive. In an Irish adult population sample only 8 per cent of men and two per cent of women were CAGE positive (Jackson, 1997). Even among men aged 20-24 Jackson's population sample only recorded a CAGE positive score of 13 per cent.

4.1.9 Medical Card Ownership

Fourteen respondents (more than half) had a medical card, however a substantial number (11) did not. This figure is almost identical to that recorded by Holohan (1997), who found that 55 per cent of respondents in his Dublin based study stated that they had a medical card. More recently Cox & Lawless (1999) recorded a figure of 57 per cent for medical card ownership among homeless drug users in Dublin. Corr (1999) reports a similar figure of 63.7 per cent among male hostel dwellers, although this figure may be effectively reduced as the medical cards belonging to 3.5 per cent had expired.

4.1.10 Service Use During the Preceding 3 Months

An extensive list of possible service providers was included in the survey instrument. However only those services used by the study population are reported upon. As can be seen from Table 8 even the small population of 25 involved in this element of the study use a considerable amount of state and voluntary services. As Timms & Balázs (1997: 536) state in their review of health and homelessness: 'although the absolute numbers are small, homeless people place disproportionately large demands on services'. It is however re-assuring to note that 40 per cent (10) of respondents were in contact with addiction services at the time of administration of the survey questionnaire. However the fact that the figure for the three month period was 48 per cent (12 individuals), and if this difference represents difficulty adhering to substance abuse treatment programmes it is an issue for concern.

Table 5 Service Use During the Preceding 3 Months

Service	Percentage of Respondents Using the Named Service in the Previous 3 Months	Average Number of Times the Named Service Was Used (mean)	Percentage of Respondents Still in Contact with the Named Service
Local Authority	16	21 (n=22)	16
Drug/Alcohol Services	12	20 (n=5)	10
Psychiatric Care Services	4	9 (n=4)	3
Other Hospital Services	8	7 (n=7)	4
Other Health Board Services	16	11 (n=14)	13
Employment Training Services	6	33 (n=6)	4
Welfare Services	11	12 (n=9)	8
Prison Related Services	4	5 (n=3)	2
Focus Ireland *	25	59 (n=23)	21
Simon Community	6	31 (n=5)	2
Merchant's Quay	13	43 (n=11)	11
EHB Homeless Unit	16	8 (n=13)	12
Big Issues	1	1 (n=1)	
Missionaries of Mary	1		1
Haven House	2	4 (n=1)	2
Legion of Mary	1	8 (n=1)	1
Salvation Army	4	39 (n=3)	1
Iveagh Trust	3	2 (n=2)	1
Cedar House	4	13 (n=3)	2
Maple House	1		1

* The high rates of use of Focus Ireland services are obviously a measurement artifact

4.1.11 Respondents Comments

Respondents were asked to comment on the services provided, as well as being encouraged to discuss any other issues they thought pertinent. The following major themes in the comments received were:

- *Criticisms of Charles Street (conditions/slowness/attitude of staff)*
- *Criticism of Dublin Corporation's policy on allocation of housing*
- *Stigma of being homeless/ treated like a second-class citizen*
- *A strong desire for housing*
- *Unhappiness associated with homelessness*
- *More services needed (e.g. counsellors, legal advice, drop-in centres, creches)*
- *Need more individual attention from key workers/counsellors*
- *The feeling that some people who work with homeless people need to change their attitude*
- *Bias of gardai*
- *Criticism of residents Committees*

The high level of hopelessness and frustration among this sample of the homeless is pervasive in the questionnaire responses. The response of one individual who insisted on completing his own questionnaire sums this up when he clearly states that the reason he has remained homeless is: "*Because the system is fu**ed up"*.

4.1.12 Gaps in Services & Supports Identified by Respondents

Respondents were also asked to identify services and supports that they felt were lacking, or needed changing. The responses were many and varied, however the list is ordered by frequency of response:

- *More housing*
- *Better emergency accommodation/more hostels*
- *More workers to repair vacant flats/open up vacant flats*
- *More drop-in centres*
- *More laundry facilities*
- *out-of hours services/longer opening times (e.g. Charles Street; Focus Ireland)*
- *More social workers*
- *night-time drop-in centres for females and males with sleeping facilities*
- *More Outreach*
- *More advice centres and legal help*
- *Specific groups for homeless men suffering from depression*
- *More sensitivity and privacy in personal approach*
- *More crèche facilities*
- *More hostels for men, women and couples*
- *More hostels with no drug-users or alcoholics*
- *More blankets available in hostels*
- *More help with moving belongings to different places*
- *More self-catering units*
- *Quicker corporation response*

- *More work-related services*
- *Improved links with schools*
- *Quicker access to health services for children*
- *More access to dental services*
- *Bus passes should be given to the homeless*
- *Opposition to agencies banning individuals*

4.2.1 The Follow-up Study

Although the main survey instrument was conducted with 25 individuals an increased sample was achieved with the follow-up sheets. Information was recorded on a total of 44 people. As described earlier Follow-up sheets were to be completed each week. The three-month study covered a 13-week period and respondents were in contact with key workers at least once per week for an average of 8 weeks.

The follow-up sheets portray a disturbing picture far more graphically than the snap shot style examination conducted in most research projects, including the survey instrument described above.

4.2.2 Accommodation Difficulties

The surveyed population is highly mobile. Even in the short three-month period of the follow-up this population moved on average 2.7 times each. However this figure is probably a gross underestimate, given the fact that the 44 individuals followed for the three-month period had frequent spells out of contact. In addition a proportion of the individuals described themselves as staying with different friends, or moving too frequently between different hostels to either count or recall. Such movements were frequently interrupted by nights spent sleeping rough.

Four of the tracked respondents (9 per cent) were too afraid to use hostels, preferring instead to sleep rough. Another respondent would not enter the hostels as this would have meant he and his girlfriend being separated. Instead this couple chose to sleep rough. Although Focus Ireland are currently building emergency accommodation for families, at present only single-sex hostels exist.

Five of the participants (11 per cent) in the follow-up study returned home, or moved to stay with their extended family at some point during the 13-week period. In four cases this broke down very quickly and resulted in all four individuals having to sleep rough as a result. The fifth participant stayed with a relative for an undisclosed length of time, until due to a relationship breakdown she had to move into a hostel.

One participant was informed by Dublin Corporation during this period that her housing options were particularly limited. This participant was informed that because of her association with her former partner, local resident's committees would not consider her being housed in their areas.

Another participant was intimidated into leaving his accommodation during the study period, following an extensive period of harassment, which culminated in a petrol bomb attack against the house he was staying in.

4.2.3 Health Difficulties, Hospitalisation & Drug Misuse

The mental and physical health difficulties faced by members of the follow-up sample are significant and disturbing. Fourteen (32 per cent) of those involved in the follow-up study suffered serious physical or mental health problems at some point during the tracking period. Eight individuals (18 per cent) were either hospitalised in the three-month period, in psychiatric or general hospitals, or attended residential drug treatment centres. A small number of participants had multiple hospital admissions. Two individuals (5 per cent) attempted suicide (or parasuicide) in this short period. Drug issues were rated as a serious problem among 16 individuals (36 per cent).

4.2.4 Legal Difficulties

Six of the individuals (14 per cent) involved in the follow-up study spent time in prison during the short follow-up period. An additional three people (7 per cent) had cases against them come to court or be postponed during this period.

5.0 Conclusion

Shaping a Healthier Future (Department of Health, 1994) clearly identified the need to examine and respond to the particular health needs of vulnerable groups within our society. However half a decade later this research provides clear evidence that initiatives to date to meet the needs of the homeless are woefully inadequate. The long-term homeless are often beset by problems of drug and alcohol addiction. A particular problem in their chaotic lives appears to be poly-drug use. The long-term homeless suffer significantly worse levels of mental ill-health than the general population, as well as high levels of chronic physical illness. The high levels of hospital admission noted require intervention on both moral and financial grounds. The incidence of two suicide attempts in a group of less than 50 people over a period of just three months is highly alarming, particularly given that the estimated number of homeless people in Ireland (excluding asylum seekers) is over 5000. It seems obvious that evidence based health interventions are required to address the mental and physical health needs of the homeless (Power et al., 1999).

Accommodation provision is clearly not meeting the need of this population, as can be seen from the high level of accommodation moves experienced by this group in the three months prior to the start of this research, and the three month tracking period. The reality that a number of participants would not enter the available hostels through fear necessitates immediate government action. As Bhugra (1997:96) states '*The success of any community based service depends upon whether the users use it and are satisfied with it'*. It is obvious that using this criteria, at least some hostels are failing miserably.

This research has also noted the use of threats of anti-social eviction to coerce tenants into leaving their homes. The use of threats of legislation is an issue of grave concern as

it may be used in an arbitrary and inappropriate manner. Such abuse may not be routinely recorded on any existing information system and could go unchecked.

Another issue identified in this research includes the lack of low cost private rented sector accommodation and the redevelopment of low cost accommodation areas into high cost, high status houses and apartments. The continuing phenomenon of leaving care and becoming homeless is identified in this sample. The inadequacy of current formal aftercare provision is affront to the very name of the Department of Health and Children.

This research demonstrates that the long-term homeless overwhelmingly want settled long-term accommodation, and that they have made efforts to secure it. This research has further identified that they need it not just on moral grounds, but on the basis of physical and mental health needs. Undoubtedly a significant proportion of this population require more than just 'bricks and mortar'. However equity demands that they receive adequate and appropriate treatment and assistance.

6.0 Recommendations

Based on the findings contained within this report a set of recommendations has been formulated to address some of the key issues.

General Recommendations:

1. Services need to be based on individual client needs, this requires flexibility in terms of resourcing services, providing personnel, availability of services i.e. locations, timetabling, target group.

2. There are a myriad of government departments, statutory bodies and voluntary agencies working with homeless individuals and families either directly or indirectly through social welfare payment services, physical or psychiatric health services, educational and development services, local authorities, emergency accommodation providers, addiction treatment centres and so on; greater inter-agency coordination, but also better intra-agency communication and coordination is urgently required.

3. Continuing research is required to help service providers understand more clearly the needs as identified by the long term homeless and to ensure that customer needs are being met. In addition, more in-depth tracking of the long-term homeless is needed to ensure that people are not being left in the homeless cycle for even longer periods and that their varied and often complex needs can be identified, addressed and supported through the appropriate provision of services.

Specific Recommendations:

Medical Services

Psychiatric Services

- People with mental health needs should have access to appropriate mental health services.

- It is imperative that homeless services in contact with homeless people with mental health concerns have ease of access to mental health services and that mental health services and access to mental health professionals be provided within homeless services for example hostels and day centres.

- There needs to be greater recognition among the medical profession that homeless individuals with psychiatric needs face additional difficulties such as access to, storage of and taking of medication. It must also be recognised that the prescribed medication may be abused and/or used in conjunction with other illegal drugs and/or alcohol.

- There is a need for appropriate discharge of patients who have no permanent address. The current practice of discharging psychiatric patients to the HPU is not acceptable and is detrimental to the welfare and mental well being of the patient. Patients released from psychiatric care need on-going care and support and this is

not available through the HPU, which is primarily concerned with placing homeless individuals in emergency accommodation. In order to ensure appropriate aftercare for patients leaving state mental health facilities more supported housing is urgently needed.

General Health Services

- At present medical cards are issued based on permanent residential address a situation wholly inappropriate for homeless households. At present, temporary emergency medical cards will be provided to families and individuals attending the HPU but this system is inadequate for the 'hidden homeless' staying with friends, living in overcrowded accommodation or involuntarily sharing with family and for any other homeless family or individual not accessing the HPU. The failure of the present medical card system is forcing homeless families and individuals to inappropriately attend A&E departments.

- There needs to be greater awareness among GPs of the needs of homeless individuals/families in terms of prescribing medication. There was evidence of multiple GP use and there needs to be a system of tracking so that individuals are not attending different GPs to obtain prescription medication such as tranquillisers, sleeping pills etc.

- A dedicated health service for people who are homeless is required. The multiple use of GPs, the inappropriate use of A&E departments, prompt diagnosis and referrals and the appropriate use of obtaining, storing and taking medication could all be addressed. Such a service could also have an outreach service making contact with out-of-home individuals not currently accessing services.

- There needs to be greater access to chiropodists and podiatrists for homeless individuals.

Dental Services

- There exists a lack of access to dental services by people out-of-home and as such, there needs to be a procedure put in place to allow homeless people access these services

- The current system of allocating a medical card in one name only needs to be changed. Focus Ireland provides a medical card, in the name of the organisation, so that customers can access GP services, however, this system does not apply to dental services.

Addiction Services

The recommendations for addiction services can be divided into two:

- For those trying to come off drugs; and
- For those still using

Recovering Drug Users

- The system of accessing drug treatment services based on residential address is wholly inappropriate for the homeless population. Possession of an address should not be a precursor to obtaining addiction treatment.

- GPs of drug treatment users need to be made more aware of the issues surrounding the prescribing of anti-depressants, sleeping pills and other prescribed medicines. This research clearly shows the high level of tranquilliser and anti-depressant use and GPs need more awareness around the issue of addiction to prescription medicines. A protocol surrounding the prescribing of medication is needed.

- The current model of treatment is the medical one in which methadone is prescribed to replace heroin. However, a more holistic approach is needed; one that includes counselling, therapeutic services and some element of training or further education to help equip recovering addicts to maintain an independent and drug free life.

- There needs to be improved linkages between drug treatment programmes and other services, such as statutory and voluntary service providers and GP services.

- There is a need for more drug outreach workers based in outlying areas not just the city centre. The function of the outreach workers would be in the area of provision of advice and harm reduction and to encourage linking with services.

- There needs to be greater provision of residential detoxification programmes for addicts prior to their accessing long-term rehabilitation programmes.

- More rehabilitation rather than maintenance programmes are needed. Programmes of up to 1 to 2 years are required to provide the supports necessary for drug users to remain clean.

- Child-care facilities should be provided in residential drug treatment centres, particularly if rehabilitation programmes are to be of a long-term nature.

- Rehabilitation programmes need to be longer and supports need to be provided to the recovering user for a considerable period after immediate withdrawal, programmes of between 1 and 3 years are recommended.

Still Using

- A seven-day needle exchange is urgently needed.

- Drug-free accommodation must be provided for U18s to protect them from drug use as a result of peer pressure

- Emergency accommodation for drug users is necessary.

- Agencies working with out-of-home individuals should provide nurses to work with drug users to alleviate pressure on A&E departments

- There needs to be greater recognition that drug users tend to have greater medical needs than the general public.

Accommodation

The recommendations surrounding accommodation needs are grouped as follows:

- Emergency
- Move-on/transition
- Supported
- PRS
- Local authority
- Community Settlement

Emergency

- Additional emergency accommodation is urgently needed for the following groups:

    - Families
    - Women
    - Men U25
    - Couples
    - Drug users

- The issue of access to hostels is also an area of concern. Some hostels have entry procedures that require residents to in place by 5 p.m.; this obviously militates against an individual trying to hold down a job or any kind of "normal" lifestyle. These kinds of issues need to be addressed to enable hostel users as normal a life as possible.

Move-on/transition

- There is a clear lack of sufficient transition or move-on accommodation, particularly but not exclusively for young women.

- Separate accommodation for drug users and non-users is urgently needed, again particularly for women

- More supported housing is needed especially but not exclusively for U25s of both sexes

Supported

- A certain percentage of out-of-home families or individuals will always need supported housing for example people who are mentally ill, those with a

disability, those with long-term illnesses or caring needs. Better and more supported accommodation to provide a safe and supported environment is needed, where residents have access to medical and psychiatric services through a PHN or CPN and to other therapeutic services.

Private Rented Sector

- The issue of the level of rent allowance paid needs to be reconsidered in light of rising rents in the city.

- The issue of advancing a months rent needs to be formalised rather than leaving it in its current discretionary form. Few landlords will accept a tenant without some form of rent in advance being paid.

- A strengthened role for inspectors of hostels and private rented accommodation is required to ensure that safety and fire and other standards be met.

Local authority housing

- The use of the housing list and the method of prioritising those in need of housing are having a serious detrimental impact on single people. A quota system whereby a percentage of available housing is allocated to single out-of-home individuals needs to be considered. At present single people and couples with no dependents have no faith in the current system and many single people do not even register with the local authority believing it to be a futile exercise.

- Clearer guidelines, mechanisms for proving and mechanisms for challenging anti-social behaviour evictions and policy by the local authorities need to be put in place. Tenants complain of the lack of transparency in the system.

- Resident's committees and their role in vetting potential new tenants to their area need to be transparent and open to ensure fairness and equity.

- Greater levels of integration for people with special needs are required. In the past individuals or families with special needs were housed in certain areas, this type of housing allocation has not worked and needs to be reviewed.

Community Settlement

- There is a need for greater local community settlement services and accommodation.

- Community settlement is a long-term process for the successful transition to independent living as such greater resources at a local level need to be put in place.

- As part of the community settlement programme prevention work and education re housing rights, housing legislation, support services available, welfare rights

should be available at a community level. These services should be in place at an early stage to prevent families or individuals entering the homeless cycle.

Leaving Care

- An adequate and holistic aftercare policy for young people leaving the care of the state is urgently required. At present there are no formal guidelines or policies for the aftercare of young care leavers, part of the preparation for independent living can be achieved through the provision of appropriate supported housing for 18-25 year olds.

- Foster families need to receive more support from statutory bodies in recognition of the invaluable role they play in supporting young people. At present foster families receive no form of payment for continuing to support a young person after the age of 18 this needs to be redressed. Remuneration for fosters carers is poor and needs to be increased to reflect the importance and often difficult circumstances of their care role.

- There is the need for more supported therapeutic units for young people under the age of 18.

Leaving Prison

- Offenders on leaving prison need clear care plans in place to provide support once they begin to live independently.

- There is a need for more probation hostels, particularly, although not exclusively for women.

Prevention

The following are needed in local communities to prevent homelessness:

- Youth services
- Social workers
- Special education
- Family support workers
- Special needs assessment.

References

Bhugra, D., Bhamra, J. & Taylor, P. (1997) 'Users' views of a drop-in project for the homeless', *International Journal of Social Psychiatry*. 43(2):95-103.

Braucht, G.N., Reichardt, C.S., Geissler, L.J., Bormann, C.A., Kwiatkowski, C.F. & Kirby, M.W. (1995) 'Effective Services for Homeless Substance Abusers', *Journal of Addictive Diseases*. 14 (4): 87-109.

Browne, A. (1993) Family violence and homelessness: The relevance of trauma histories in the lives of homeless women. *American Journal of Orthopsychiatry*, 63, 370-384.

Burroughs, J., Bouma, P., O'Connor, E. & Smith, D. (1990); Health concerns of homeless women. In P.W. Brickner, I'K. Scharer, B.A. Conanan, M. Savarese & B.C. Scanlan (eds) *Under the safety net: The health and social welfare of the homeless in the United States* (pp.139-150). New York: W.W. Norton.

Cleary, A. & Prizeman, G. (1999) *Homelessness and mental health- A research report*. Dublin: Social Science Research Centre, UCD.

Collins, B. & McKeown, K. (1992) *Referral and Settlement in the Simon Community*. Dublin: Simon Community National Office.

Conover, S., Berkman, A.B., Gheith, A., Jahiel, R., Stanley, D., Geller, P.A., Valencia, E. & Susser, E. (1997) 'Methods for Successful Follow-up of Elusive Urban Populations: An Ethnographic Approach with Homeless Men', Bulletin Of The New York Academy Of Medicine. 74(1): 90-108.

Corr, C. (1999) *Health and Homelessness: Health status and health care access of single homeless men living in hostels in inner city Dublin*. Unpublished MSc. Thesis. Dublin: TCD.

Cousineau, M.R. (1997) 'Health status of and access to health services by residents of urban encampments in Los Angeles', *Journal of Health Care for the Poor and Underserved*. 8 (1): 70-82.

Cox, G. & Lawless, M. (1999) Where-ever I lay my hat … A study of out of home drug users. Dublin: Merchant's Quay Project.

Department of Health (1994) *Shaping a healthier future*. Dublin: Department of Health.

Department of Health (1995) *A Health Promotion Strategy*. Dublin: Department of Health.

Department of the Environment (1999). Molloy Publishes Results of Local Authority Assessments of Housing Needs. http://www.environ.ie/press/assessment99.html

Eastern Health Board (1987) *Homeless Young People*. Unpublished Report.

Eastern Health Board (1994) *Homeless Young People*. Unpublished Report.

Fahey, T. & Watson, D. (1995) *An Analysis of Social Housing Need*. General Research Series, Paper No. 168. Dublin: Economic and Social Research Institute.

Feeney, A., McGee, H., Holohan, T. & Shannon, W. (2000) *Health of Hostel-Dwelling Men in Dublin*. Dublin: RCSI & EHB.

Focus Point and The Eastern Health Board (1989*) Forgotten Children – Research on Young People Who Are Homeless In Dublin*. Dublin: Eastern Health Board and Focus Project Limited.

Gelberg, L., Gallagher, T.C., Anderson, R.M. & Koegel, P. (1997) 'Competing Priorities as a Barrier to Medical Care among Homeless Adults in Los Angeles', *American Journal of Public Health*. 87(2):217-220.

Gelberg, L. & Linn, L.S. (1989) 'Assessing the Physical Health of Homeless Adults', *JAMA*, 262:1973-9.

George, S.L., Shanks, N.J. & Westlake, L. (1991) 'Census of Single Homeless People in Sheffield', *British Medical Journal*, 302: 1387-9.

Gillis, L.M. & Singer, J. (1997) 'Breaking through the barriers: Healthcare for the homeless', *JONA*. 27(6): 30-34.

Harway, M. (1984) Some practical suggestions for minimising subject attrition. In: S.A. Mednick, M. Harvey, & K.M. Finello (eds) *Handbook of Longitudinal Research. Vol. 1.* New York: Praeger.

Hibbs et al., (1994) 'Mortality in a cohort of homeless adults in Philadelphia', *New England Journal of Medicine*. 331: 304-9.

Holohan, T. (1997) *Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin*. Dublin: Eastern Health Board.

Jackson, T.M.R. (1997) *Smoking, Alcohol and Drug Use in Cork and Kerry. Cork*: Department of Public Health, Southern Health Board.

Jenkinson, C. & Layte, R. 'Development and testing of the UK-SF-12', *Journal of Health Service Research & Policy*, 2 (1): 14-18.

Jenkinson, C. & Layte, R., Jenkinson, D., Lawrence, K., Petersen, P., Paice, C. & Stradling, J. (1997) 'A Shorter form health survey: can the SF-12 replicate results from the SF-36 in longitudinal studies?', *Journal of Public Health Medicine*, 19(2): 179-186.

Keane, C. and Crowley, G. (1990) *On My Own. Report On Youth Homelessness In Limerick City*. Limerick: Mid-Western Health Board and Limerick Social Service Centre.

Kelleher Associates (1998) *Out on Their Own. Young People Leaving Care in Ireland*. Dublin: Focus Ireland.

Kelleher, C. et al. (1999) *The National Health and Lifestyle Surveys*. Galway: Centre for Health Promotion Studies, National University of Ireland, Galway.

Kennedy, S. (1985) *But Where Can I Go? Homeless Women in Dublin*. Dublin: Arlen House.

Koegel, P. (1992) 'Through a different lens: an anthropological perspective on the homeless mentally ill', *Cult Med Psychiatr*. 74(1): 90-108.

Leonard, L. (1992) 'Official Homelessness Figures Show only Tip of Iceberg', *Simon Community Newsletter*, No. 180. Dublin: Simon Community National Office.

Link, B.G., Susser, E., Stueve, A., Phelan, J., Moore, R.E. & Struening, E. (1994) 'Lifetime and Five-Year Prevalence of Homelessness in the United States', *American Journal of Public Health*, 84: 1907-12.

MacNeela, P. (1999) 'Homelessess in Galway', *The Journal of Health Gain*, 3(2): 8-10.

Marshall, M., Nehring, J., Taylor, C. & Gath, D. (1994) 'Characteristics of homeless mentally ill people who lose contact with caring agencies', *Irish Journal of Psychological Medicine*, 11 (4): 160-3.

Moore, J. (1994) *B&B in Focus. The Use of Bed and Breakfast Accommodation for Homeless Adults in Dublin*. Dublin: Focuspoint.

O'Morain, P. (1999) 'Housing ambitions of earlier decades have come to grief', *The Irish Times*, 7 September.

O'Sullivan, E. (1996) *Homelessness and social policy in the Republic of Ireland*. Department of Social Studies Occasional Paper No.5. Dublin: TCD.

Ramsden, S.S., Nyiri, P., Bridgewater, J. & El-Kabir, D.J. (1989) 'A mobile surgery for single homeless people in London', *British Medical Journal*. 298: 372-4.

Schlay, A.B. & Rossi, P.H. (1992) 'Social Science Research and Contemporary Studies of Homeless', *Annual Review of Sociology*. 18: 129-160.

Shanks N. (1981) 'Consistency of data collected from inmates of a common lodging house', *Journal of Epidemiology & Community Health*. 35: 133-5.

Southern Health Board (1996) *Review of Adequacy of Child Care and Family Support Services*. Kilkenny: Southern Health Board.

Susser, E.S., Lin, S.P., Conover, S.A. & Struening, E.L. (1991) 'Childhood antecedents of homelessness in psychiatric patients', *American Journal of Psychiatry*, 148, 1026-1030.

The Standing Conference On Public Health (1994) *Housing, Homelessness And Health. Working Group Report*. London: The Nuffield Provincial Hospitals Trust.

Timms, P. & Balázs, J. (1997) 'ABC of mental health: Mental health on the margins', *British Medical Journal*. 315: 536-539.

Van Hook, M.P. & Ford, M.E. (1998) 'Health status of homeless and marginally housed users of mental health self-help agencies', *Health & Social Work*. 23 (1): 45-52.

Wood, N., Wilkinson, C. & Kumar, A. (1997) 'Do the homeless get a fair deal from General Practitioners?', *Journal of the Royal Society of Health*. 117 (5): 292-297.

Wright, J.D., Allen, J.L. & Devine J.A. (1995) 'Tracking non-traditional populations in longitudinal studies. *Eval Program Planning*. 18: 267-277.

Wright, Devine & Joyner's (1993) *The least of mine: the New Orleans Homeless Substance Abusers Project Final Report*. Washington, DC: National Institute of Alcohol Abuse and Alcoholism.

Wright, J.D. & Joyner, L.M. (1997). Health Behavior among the Homeless and the Poor. In D.S. Gochman (ed.) *Handbook of Health Behaviour Research III: Demography, Development and Diversity*. New York: Plenum Press.

Appendix 1
FOCUS IRELAND

SERVICE USE STUDY

CONFIDENTIAL

Focus Ireland is concerned that there are a number of people in Ireland who have been homeless for an extended period of time. Focus Ireland is therefore conducting a piece of research to examine service use of people who have been homeless for more than six months. It is hoped that this research will allow improvements to be made in services by highlighting the problems encountered by people who have been homeless for this length of time. The survey form includes questions about your background and health to help us build up a profile. The survey also includes questions about how you became homeless and the services you have used in the last three months.

The second stage of the research project involves asking you again in the future what services you have used since completing the first questionnaire.

Your help and co-operation in taking part in this survey is requested. You do not have to complete this survey and if you choose not to this will not in any way affect your access to Focus Ireland's services. However your help is needed if services are to be improved. Therefore please take the time to participate if you can.

The information collected in this project is strictly confidential. No individuals will be named or identified in the research report. When this survey is finished the questionnaires will be shredded and destroyed.

1. IDNO: **(For R,D&E Use)**

2. QUESTIONNAIRE COMPLETED ON:

3. QUESTIONNAIRE COMPLETED BY:

4. NAME OF KEY WORKER: (If different from above)

5. SERVICE IDENTIFYING RESPONDANT:

----

6. ARE YOU CURRENTLY HOMELESS?	**YES NO**

7. HAVE YOU BEEN HOMELESS FOR SIX MONTHS OR MORE?	**YES NO**

If the answer to either question 6 or 7 is 'NO' end the interview.

8. What is your name?

9. Sex:	**Male**	**Female**

10. What is your date of birth?

11. Where are you currently staying?

12. Over the last week how many nights have you spent…

	No. of nights
Sleeping rough	
Sleeping in a hostel	
Sleeping in a B&B	
Sleeping in a refuge	
Squat	
Sleeping in friend's house because you had nowhere else to go	
Staying in your own house/flat etc.	
Staying in Transition housing	

Staying in a Hospital	
Staying in a Prison /Garda station	
Other (please specify)	
TOTAL	(Does this sum to 7 nights?)

13. What is your marital status:	Single (Never Married)	Married/ Living as Though Married	Separated/ Divorced/ Widowed

14. What is your family status:	Alone	Alone With Children	With Partner	With Partner & Children	Other (please specify)

15. Do you have children being taken care of by someone else or in care?	Yes No

16. If with children please give the number of children:	

17. If with children please give their ages:	

18. Is this the first time that you have been homeless?	**YES NO**

If 'YES' please go to question 21

19. If 'NO' how many times have you been homeless?	

20. If 'NO' when did you first become homeless (approx.):	

21. When did you become homeless (this time)?	

22. How long was there between you becoming homeless and your first contact homeless service (this time):	

23. Location of housing before becoming homeless (broad area e.g. Inchicore, Tallaght):	

24. Type of housing before becoming homeless:	Local Authority Rented	Shared Ownership Scheme	Local Authority Tenant Purchase	Private Rented	Private Owner Occupied	In Care	Other (please specify)

25. Housing arrangements before becoming homeless:	Alone	Lone Parent	Family Of Origin	Partner	With Friends/ Relatives	In Care	Other (please specify)

26. Is your name on a local authority housing list?	**YES NO**

27. If yes which ones?	**Dublin Corporation** **South Dublin County Council** **Dun Laoghaire/Rathdown Co. C.** **Finglas County Council** **Others (please specify)**

28. Under what circumstances will the Local Authority re-house you?	

29. Main Reason for becoming homeless?

	MAIN REASON (tick <u>one</u> only)		**SECONDARY REASONS (tick <u>each</u> that applies)**
Relationship problems			
Family conflict			
Domestic violence/ physical abuse			

Sexual abuse			
Drug related problems			
Alcohol related problems			
Unfit Accommodation			
Overcrowded Accommodation			
Actually evicted under anti-social legislation from Local Authority housing			
Threatened with anti-social legislation eviction in Local Authority housing			
Evicted (not under anti-social legislation) from Local Authority housing			
Evicted / given notice to quit from private rented accommodation			
Barring order			
Financial reasons			
Released from prison			
Left residential care			
Physical health problems			
Mental health problems			
Involuntary sharing/need for independence			
Returned to Ireland			
Tenure insecure			
Other (please specify)			

30. Why do you think you have remained homeless?	

31. Level of schooling completed:

	Educational level	Indicate one item
I	**No education beyond primary level**	
II	**Some second level education**	
III	**Group Cert. or equivalent**	
IV	**Intermediate Cert. or equivalent**	
V	**Leaving Cert. or equivalent**	
VI	**Certificate/Diploma**	
VII	**University Degree or equivalent**	
VIII	**Postgraduate degree or diploma**	
IX	**Other (please specify)**	

32. Source of household income:

	Income source	Indicate all items which apply
I	**Employment**	
II	**Simon Work Project**	
III	**Unemployment Benefit/Assistance**	
IV	**Lone Parent Allowance**	
V	**Widow(er)'s Pension**	
VI	**Retirement Pension**	
VII	**Disability Income**	
VIII	**Supplementary Welfare Allowance**	
IX	**Family Income Supplement**	
X	**Begging**	
XI	**Training scheme (e.g. FAS)**	

XII	**Other income (please specify)**	

33. Are you actively seeking long-term accommodation?	YES NO

This part of the questionnaire asks for your views about your health. This information will help us understand how you feel and how you are able to do your usual activities. Please answer every question. If you are unsure about how to answer, please give the best answer you can.

34. In general, would you say that your health is:

Excellent	Very Good	Good	Fair	Poor

The following items are about activities you might during a typical day.
Does your health now limit you in these activities? If so, how much?

35.	**Moderate activities, such as moving a table, pushing a vacuum cleaner or bowling.**	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
36.	**Climb several flights of stairs**	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All

During the <u>past 4 weeks</u>, have you had any of the following problems with your regular daily activities <u>as a result of your physical health?</u>

37.	**Accomplished less than you would like.**	Yes	No
38.	**Were limited in the kind of regular activities**	Yes	No

During the <u>past 4 weeks</u>, have you had any of the following problems with your regular daily activities <u>as a result of emotional problems</u> (such as feeling depressed or anxious)?

39.	**Accomplished less than you would like.**	Yes	No
40.	**Didn't do regular activities as carefully as usual**	Yes	No

41. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your regular daily activities (inside and outside)?

Not At All	A Little Bit	Moderately	Quite A Bit	Extremely

The following questions are about how you feel things have been for you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks-

42.	**Have you felt calm and peaceful?**	All Of The Time	Most Of The Time	A Good Bit Of The Time	Some Of The Time	A Little Of The Time	None Of The Time
43.	**Did you have a lot of energy?**	All Of The Time	Most Of The Time	A Good Bit Of The Time	Some Of The Time	A Little Of The Time	None Of The Time
44.	**Have you felt downhearted and blue?**	All Of The Time	Most Of The Time	A Good Bit Of The Time	Some Of The Time	A Little Of The Time	None Of The Time

45. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

All Of The Time	Most Of The Time	Some Of The Time	A Little Of The Time	None Of The Time

46. Do you have any chronic long standing illness or disability?

Yes	No

47. If 'Yes' please give details:

48. Have you ever been assessed for, or diagnosed as suffering from a psychiatric illness? Yes No

49. If 'Yes' please give details:

ALCOHOL

50. How long ago did you have an alcoholic drink?	During the last week	One week to one month ago	One month to three months ago	Three to twelve months ago	More than twelve months ago	Never had alcohol beyond a sip or taste

If respondent has 'Never had alcohol beyond a sip or taste' or not for 'More than twelve months' please go to question 58.

51. Thinking about your drinking in the last year did you usually drink alcohol in a typical week?	YES	NO

If 'NO' please go to question 58.

52. On how many days during a typical week did you usually drink alcohol on average?	(No.)

53. On the days you drank alcohol how many drinks would you have on average? Please note a 'drink' is defined as: - half a pint of beer/cider - a glass of wine - a single measure of spirits	No. of 'drinks':

	CAGE		
54.	**Have you felt you needed to cut down on your drinking?**	**YES**	**NO**
55.	**Have you felt annoyed by criticism of your drinking?**	**YES**	**NO**

56.	**Have you felt guilty about drinking?**	**YES**	**NO**
57.	**Have you felt you needed a drink first thing in the morning?**	**YES**	**NO**

ILICIT DRUG USE

58. Have you ever used an illegal drug, or a prescribed drug (such as sleeping pills, tranquillisers or methadone) more than you were supposed to?	YES NO

If the answer is 'NO' please go to question 70.

DRUG	**Ever Taken**	**Taken In The Last Month**
59. Sleeping pills, Barbiturates, Sedatives, Downers, Seconal	**YES NO**	**YES NO**
60. Tranquillisers, Valium, Librium	**YES NO**	**YES NO**
61. Cannabis, Marijuana, Hash, Grass, Ganja, Kif	**YES NO**	**YES NO**
62. Amphetamines, Speed, Uppers, Stimulants, Qat	**YES NO**	**YES NO**
63. Cocaine, Coke, Crack	**YES NO**	**YES NO**
64. Heroin, Smack	**YES NO**	**YES NO**
65. Opiates other than heroin, Demerol, Morphine, Darvon, Opium, DF118	**YES NO**	**YES NO**
66. Psychedelics, Hallucinogens: LSD, Mescaline, Acid, Peyote, Psylocybin, (magic) mushrooms	**YES NO**	**YES NO**
67. Ecstasy	**YES NO**	**YES NO**
68. Solvents, inhalants, glue, amyl nitrate	**YES NO**	**YES NO**

69. Can I just check, have you ever injected yourself with drugs?	YES NO

70. Do you have a medical card?	**YES NO**

SERVICE USE

71. Have you had contact over the last three months with any of the following services ?

	In last 3 months ?	Why?	How often	Comments	Still in contact?
Local Authority	YES NO				YES NO
Drug/ alcohol services	YES NO				YES NO
Psychiatric care services	YES NO				YES NO

	In last 3 months ?	Why?	How often	Comments	Still in contact?
Other Hospital services	YES NO				YES NO
Other Health Board Services	YES NO				YES NO
Employme					

nt training services	YES NO				YES NO
Welfare services	YES NO				YES NO
Prison related Services	YES NO				YES NO
Focus	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Simon	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Back Lane	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Aids Housing Fund	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4-			YES NO

		Accom/Housing 5-			
	In last 3 months ?	Why?	How often	Comments	Still in contact?
Merchant's Quay	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
EHB Homeless Unit	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Threshold	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Women's refuge	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Vincentian Housing Partnership	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Big Issues	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4-			YES NO

		Accom/Housing 5-			
Daisyhouse Housing Association	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Missionaries of Mary	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Haven House	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Legion of Mary	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Salvation Army	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO

	In last 3 months ?	Why?	How often	Comments	Still in contact?
Iveagh Trust	YES	1- Practical help 2- Advice/info			YES

	NO	3- Support/couns 4- Accom/Housing 5-			NO
Sonas Housing Association	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Portland Row	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Cedar House	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO
Maple House	YES NO	1- Practical help 2- Advice/info 3- Support/couns 4- Accom/Housing 5-			YES NO

72. Thinking about yesterday (last weekday) can you tell me about all the services did you used or came into contact with? (please list them in the order in which they were encountered or number them to indicate this)

73. If you have had to move accommodation any time in the previous three months can you please tell me where and why?

74. Can you tell me what services or supports for homeless people you feel would help but which are not available currently?

75. Do you have any other comments? (Please write these on the back of the questionnaire)

THANK YOU VERY MUCH FOR TAKING PART IN THIS SURVEY. ALL RESPONSES WILL BE TREATED AS HIGHLY CONFIDENTIAL. WHEN THE INFORMATION HAS BEEN ANALYSED THESE QUESTIONNAIRES WILL BE SHREDDED.