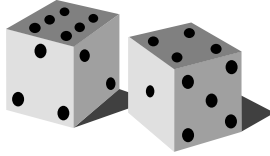


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# WHEREVER I LAY MY HAT....

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## **A STUDY OF OUT OF HOME DRUG USERS**

BY

GEMMA COX

MARIE LAWLESS

This report was made possible through funding from the Combat Poverty Agency. The views expressed in this report are those of the authors and do not necessarily reflect the views of the Combat Poverty Agency.

# Wherever I lay my hat.....

A STUDY OF OUT OF HOME DRUG USERS



Cover Design by: Ann Marie Harran

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**Contact: The Merchant's Quay Project**

4 Merchant's Quay

Dublin 8

Tel: 6790044

Fax: 6713738

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# ACKNOWLEDGEMENTS

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The Merchant's Quay Project is indebted to all respondents who agreed to participate in the research study.

This research would not have been possible without the support of staff members of the Contact Centre.

We would like to express sincere thanks to Mary O'Shea and Linda Cox for ensuring the continuous progress of the research study.

This Report has been prepared with the support and co-operation of the following; Tony Geoghegan (MQP-Director), Dermot Kavanagh (MQP-Resource and Development Officer) and Gerry Raftery (FSJI-Director)

We gratefully acknowledge the funding provided by the Combat Poverty Agency under the Project entitled "Poverty, Drug Use and Policy".

# EXECUTIVE SUMMARY

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The Merchant's Quay Project was established in 1989 by the Franciscan Community in response to an increase in the number of drug users seeking help within the locality. As a voluntary organisation the Project is receptive to the needs of its service users and has the flexibility to respond accordingly. The Project provides a range of services, operating across a broad spectrum of treatment philosophies, thus providing a holistic approach to drug treatment, one such facility is the Contact Centre. The Contact Centre is the first point of contact for individuals who wish to avail of a range of services such as; crisis intervention, needle exchange, art room, holistic therapy etc. The Merchant's Quay Project has always being acutely aware of the relationship between social deprivation and drug use. More recently it has being concerned with the increasing numbers of homeless drug users presenting at the Project. In 1996, the Merchant's Quay Project and the Franciscan Social Justice Initiatives participated in the Project "Poverty, Drug Use and Policy" supported by the Combat Poverty Agency.

## RESEARCH OBJECTIVES

The objectives of this research study are as follows;

- To research the national and international information available on the relationship between homelessness and drug use;
- To identify the extent of homelessness among drug users who present at the Merchant's Quay Project's Contact Centre;
- To examine the sleeping arrangements of homeless drug users who present at the Contact Centre and it's impact on respondents risk behaviour;
- To inform local and national policy makers on the relationship between drug use and homelessness.

## RESEARCH METHOD

This study employed two research instruments. The first, a *Screening Questionnaire*, which was designed and administered to all consenting clients who presented at the Project's Contact Centre during the week of the 8<sup>th</sup>-12<sup>th</sup> February 1999. A total of 190 active drug users agreed to complete this questionnaire. This instrument identified 120 drug users, who were eligible to participate in the *Survey of Out of Home Drug Users*. In order to be eligible to participate in the survey an individual had to be active drug users and conform to the definition of homelessness employed in the research, that is, their current accommodation must be either a hostel, B&B, squat, staying with friends and relatives or sleeping rough. A total of 53 individuals completed the survey, that is 44% of the homeless drug users identified. Information was collected on a number of areas including; current accommodation, history of homelessness, drug use, risk behaviour and health and well being.

## KEY RESEARCH FINDINGS

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### SCREENING QUESTIONNAIRE

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During the week of the 8<sup>th</sup> to the 12<sup>th</sup> of February 1999, 75% (n=190) of the clients who presented at the Contact Centre of the Merchant's Quay Project agreed to complete the screening questionnaire. Some notable findings include;

- 69% of the respondents were male and the remaining 31% were female.
- The average age of clients presenting at the Contact Centre was 24.9 years (range 16-43 years); female respondents were significantly younger than their male counterparts.
- 63% (n=120) of respondents were classified as being currently homeless;
  - 32% were sleeping rough;
  - 35% were staying in hostels;
  - 11% were in B&B's;
  - 20% were with friends and relatives;
  - 2% were in squats.
- Female respondents were more likely to report staying in a B&B, 15% percent of female clients reported currently staying in a B&B, while only 3% of male clients reported living in this type of emergency accommodation.
- Only 7% of the clients interviewed reported that they had never experienced being homeless.
- Of those who have ever experienced homelessness, 57% reported staying in emergency accommodation (i.e. hostel and B&B) and 44% reported having slept rough.
- More than one in every two of the clients who ever experienced homelessness attributed this directly to their drug use.

\* \* \* \* \*

## KEY RESEARCH FINDINGS

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### SURVEY OF OUT OF HOME DRUG USERS

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Of the 120 active drug users who were identified as being homeless, 53 completed the survey of *Out of Home Drug Users*. Key features included;

#### *Demographics*

- ? Sixty two percent of the respondents were male and the remaining 38% were female.
- ? Mean age for the sample of homeless drug users was 24.4 years (range 16-25 years); female respondents were proportionately younger than their male counterparts, in that women were on average 22.8 years of age, while male clients were on average 25.5 years.

#### *Client Vulnerability*

- ? The client group are extremely vulnerable by virtue of their drug use, low educational attainment, and legal status, all of which exacerbates their social exclusion. In summary, 98% of the sample were IV heroin users. They had initiated their drug use at a relatively young age (mean=15 years). At the time of interview, the average length of respondents drug injecting career was 5.2 years. The majority of clients (71%) left school before the legal school leaving age of 16 years. All respondents reported being unemployed at the time of interview, and only 34% stated that they were claiming dole and/or assistance as a source of income. Regarding legal status, fifty percent of respondents reported that they had previously served a prison sentence, and 50% also reported having being remanded in prison. Forty percent of the respondents reported being currently on bail, 30% on probation, and 18% on temporary release.

#### *Homelessness*

- ? Clients sleeping arrangements were as follows;
  - 28% were in hostels;
  - 12% were in B&B's;
  - 32% were with friends and relatives;
  - 28% were sleeping rough.
- ? Sleeping arrangements are highly influenced by gender. For example, male respondents were proportionately more likely than their female counterparts to report staying in hostels, while female respondents were more likely to report staying in a B&B or with relatives and friends.
- ? Age also had an impact on where clients reported staying. Those who reported sleeping rough were on average younger than clients in other types of accommodation. The average age of clients who reported sleeping rough was 22.7 years (range 16-34 years) compared with an average of 25.2 years for those in other categories of accommodation.

- ? Analysis revealed that 83% of the respondents identified themselves as being homeless.
- ? 64% of respondents attributed their homeless status to their drug use. However, interpersonal problems were also reported as a contributing factor to their homelessness, for example 38% of respondents reported having left home due to family conflict and 15% due to relationship breakdown.
- ? 41% of clients reported that their current episode of homelessness was their first. The average age of first homelessness for the cohort was 19.2 years and clients were out of home for an average of 2.26 years.
- ? A number of clients did report that they had being forced out of accommodation; 10% reported that they had at some point in time been forced out of accommodation due to vigilantism. In addition, twelve percent of the client group stated that they were forced to leave accommodation due to pressure from tenants or residents` associations.

#### *Contact With Services*

- ? Homeless Services - Levels of contact with services for the homeless were relatively high, in that, (86%) of the respondents reported that they were attending at least one centre that explicitly provided services for the homeless. The reported contact with homeless services was highly influenced by the individual`s current sleeping arrangements. For example, those sleeping rough were more likely than any other client group to avail of the Simon Soup Run. More surprisingly, were the gender differences in reported contact with such services, for example female respondents (63%) were more likely than their male counterparts (31%) to report contact with the Dublin Corporation.
- ? Drug Services - Approximately one third of the respondents (34%) reported that they were attending another drug treatment service at the time of interview. A further 36% reported that they had at some point in time experienced previous drug treatment. A final 30% of respondents reported not having attended any drug treatment service apart from the Merchant`s Quay Project.
- ? Medical Services- Despite numerous physical and mental health complaints, only 52% of respondents reported contact with a G.P in the three months prior to interview. Moreover, 44% of the cohort reported having been to a casualty department, and 16% had reported contact with more specialist services.

#### *Impact of Homelessness*

- ? 66% of the clients reported that their drug use had changed since being out of home, the majority stating that they were either using more frequently or more erratically. The homeless drug users interviewed also engaged in very high levels of risk behaviour with 66% of clients injecting in public places and only 30% injecting alone. These factors contributed to the high levels of sharing, in that 49% of the respondents reported sharing injecting paraphernalia, 16% reported recently lending their injecting equipment and a further 24% reported recently borrowing used injecting equipment.
- ? Clients reported suffering from a range of physical and mental health

complaints, some of which clients attributed to their homelessness and all of which were further exacerbated by their homeless status.

- 7 The lack of a private place of residence increases homeless drug users' exposure to the police. Therefore, it was not surprising that 68% of the respondents reported that they had been harassed by the police since being out of home. Moreover, 44% of respondents reported that they had been the victim of a crime since they became homeless.

### *Implications of Study*

This research indicates high levels of homelessness among a sample of chaotic drug users. It also provides some insight into the impact of homelessness on these individuals. In order to gain more accurate information on the extent of homelessness among problem drug users, and its consequences, more quantitative and qualitative research must be undertaken. Despite the limitations of this study, it provides valuable information which has implications for both drug service providers and homeless service providers.

- 7 Drug Service Providers need to be made aware of the changing profile of problem drug users, in that, a significant proportion of their clients either are currently, or will in the future, experience homelessness. Moreover, out of home drug users are not a homogenous group, they have varying needs depending largely on homeless classification. The engagement of this group in high levels of risk behaviour demands a restructuring of services, in terms of both practice and their impact on policy making.
- 7 Homeless Service Providers need to be made aware that an increasing number of their clients are and will be problem drug users. To this end, training and education on drug use and related issues is essential for those who engage with this client group on a daily basis. In addition, it is necessary to locate such an awareness within services provided, such as identifying this client group as a high priority group and putting an end to the exclusion of drug users from accessing such services. In short, homeless drug users highlight that an effective homeless policy cannot focus simply on the provision of accommodation, but rather it must be located within the broader context of social policy and social exclusion.

# CHAPTER ONE

## INTRODUCTION

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### 1.1 BACKGROUND TO THE STUDY

The Merchant's Quay Project provides a model for working with drug users<sup>8</sup> who engage in risk behaviour<sup>2</sup>, which concentrates on reducing or eliminating those risks. Over the years the number of drug users attending the Project has increased rapidly. Moreover, the Merchant's Quay Project has become acutely aware of the increased number of homeless drug users presenting at the service. This is highlighted by the fact that 19% of new clients attending the Health Promotion Unit between 1997 and 1998 reported being homeless (Cox and Lawless, 1999). While anecdotal evidence suggests that homelessness impacts on drug use, this has been supported by research carried out within Merchant's Quay. Findings revealed not only that homelessness was a predictor of injecting risk behaviour among respondents, but also that homeless categories highly influenced risk behaviour. For example, respondents who reported living in emergency accommodation were significantly less likely to report sharing injecting equipment than those sleeping rough (Cox and Lawless, 1999). International research indicates that homelessness and drug use are connected, yet the nature of this association is uncertain and under researched (Seddon, 1998; Flemen, 1997).

The following research study is one of the first in Ireland to examine drug use and homelessness in any depth. It is not intended to illustrate the causes of homelessness among drug users, but rather it provides an exploratory analysis of individuals in such circumstances. Contemporary studies have illustrated that the homeless population is changing (Kemp, 1997), in that, it is getting younger and it is increasingly made up of a greater proportion of females than before (Smith, 1999). At the same time, there has been an increase in the number of visible homeless, more specifically the number of rough sleepers within the homeless population (Carlen, 1996). Rough sleepers provide a visible example of a 'vulnerable lifestyle' highlighted both by their appearance and behaviour. In a modern inner city, the 'vulnerable' represent a constant feature of that city which reflects not only the circumstances of the individuals but also the state of the city as a whole. Often, descriptions of the individual characteristics of homeless people, such as mental illness, alcoholism, and drug use, have been inappropriately interpreted as explanations of their homelessness. As will be discussed in more detail within this study, such simple explanations tend to ignore or minimise structural or environmental factors that influence the extent and course of homelessness.

Nugent (1996) states that the three main characteristics of the 'vulnerable' inner city population are deprivation, diversity and population instability which when combined demonstrate a high level of need. All these features are present within the present drug using population and more acutely among the homeless drug using population. According to Frischer (1989) the experience of homelessness is not a random occurrence that is independent of individual characteristics or experiences. Problems such as drug use represents an additional "burden of vulnerability" for homeless and other low-income populations. Other burdens include the lack of affordable housing, low social welfare benefits, and poverty. However, homeless drug users are treated differently because of both their illegal drug use and their homeless status. Consequently, they are at greater risk of falling into the

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<sup>8</sup> The language used to describe individuals who take drugs and/or the consequences of their drug use can be very emotive. Terms such as 'drug abuser', 'drug misuser' or 'problem drug user' are often used without any explanation. Hartnoll *et al* (1985) argues that it is essential to define the terms used, as any ambiguity surrounding definitions has important implications for the interpretation and generalisation of results. In this Report the term 'problem drug user' and 'chaotic drug user' are used interchangeably and refer to an individual who, as a result of taking psychoactive drugs, suffers either medical, psychological or social complications. These terms recognise that illicit drug use can cause a range of problems among regular consumers. The terms employed do not refer exclusively to injecting opiate users, however the majority of individuals who present at the Merchant's Quay Contact Centre fall into this category.

<sup>2</sup> The terms 'risk' and 'harm' are often used synonymously when related to drug users behaviour. However, Strang (1999) argues that *risk* relates to the possibility than an event might occur, on the other hand *harm* is seen as the event itself, or as relating to the event. In short, risk behaviour does not inevitably result in harm, thus one can only argue that risk behaviour such as needle sharing may result in individual, community and/or social harm.

group of so called 'disreputable homeless' who are treated badly by a society which seeks only to assist the 'deserving poor'. In other words, individuals who engage in a self-destructive and 'deviant' lifestyle tend not to be regarded as deserving of housing as others (Carlen, 1996).

Drug workers at the Merchant's Quay Project are acutely aware of the increase in the number of homeless drug users presenting at the service. However, very little research has been carried out on the extent and nature of homelessness among this client group. This is primarily due to the fact that homelessness among the age group predominantly engaging in illicit drug use (those under 25) is a fairly recent phenomenon (McCarty *et al*, 1991). Moreover, the nature of the relationship between homelessness and drug use is quite controversial, and the debate often focuses on the direction of the relationship and causal association. While drug use and alcohol use appears disproportionately among the homeless population, they cannot by themselves be used as an explanation for homelessness. However, homelessness no doubt has an impact on an individual's drug use and vice versa. In order to examine this in more detail, the Merchant's Quay Project in conjunction with the Combat Poverty Agency decided to undertake research on the experiences of out of home drug users.

## 1.2 OBJECTIVES OF THE STUDY

The Combat Poverty Agency is committed to contributing to, and complementing current efforts, at both local and national levels, to address the drugs issue. In particular, the Agency is concerned with examining the links between poverty and drug use, and supporting local groups who are tackling the issue of drugs in their area through community development approaches. The Merchant's Quay Project and the Franciscan Social Justice Initiatives are jointly engaged in a project focusing on **"Poverty, Drug Use and Policy"** which is supported by the Combat Poverty Agency. This report provides some insight into the experience of homeless drug users and aims to inform local and national decision-makers at a policy level.

The objectives of the study are as follows;

- To research the national and international information available on the relationship between homelessness and drug use;
- To identify the extent of homelessness among drug users who present at the Merchant's Quay Project's Contact Centre;
- To examine the sleeping arrangements of homeless drug users who present at the Contact Centre and it's impact on respondents risk behaviour;
- To inform local and national policy makers on the relationship between drug use and homelessness.

## 1.3 THE REPORT

This report examines the extent and nature of homelessness among a sample of injecting drug users who present at the Merchant's Quay Project Contact Centre. In **Chapter Two**, both international and national literature on homelessness and drug use is outlined and critically analysed. It will be seen that while a theoretical body of research exists, the difficulties with defining and measuring homelessness has resulted in a lack of empirical studies in the area. An extensive literature review revealed that



limited research has been undertaken on homelessness in Ireland, and even less has been concerned with homeless drug users. **Chapter Three** outlines the research methods employed in achieving the objectives of the study. The design and implementation of the two research instruments, the Screening Questionnaire, and the Survey of Out Of Home Drug Users are discussed. **Chapter Four** and **Five** present an analysis of data collected from the clients who agreed to participate in the research study. Chapter Four, analyses the data collected from the 190 clients who completed the screening questionnaire. Chapter Five provides a detailed analysis of the experience of the 53 homeless drug users who completed the survey. These chapters also highlight some of the main areas of concern to emerge from the data collected. The report concludes with **Chapter Six**, which offers a summary of the main findings and presents various conclusions and policy recommendations.

# CHAPTER TWO

## LITERATURE AND CONCEPTUAL FRAMEWORK

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### 2.1 INTRODUCTION

Homelessness and the homeless are twentieth-century productions. Vagrants, paupers, tramps, slum-dwellers, street children and the poor pre-exist the homeless. However, as Carlen (1996) argues,

“it took the inadequate welfare states of the twentieth century to create homelessness as a finely-tuned, bureaucratic instrument for defining, indexing, redeploying, normalising and abnormalising the young, unemployed homeless as one welfare class too many” (Carlen, 1996:11).

In short, there has always been a substantial minority of people who for a variety of reasons have been unable to provide or maintain housing for themselves or their family. While contributing factors have changed over time, poverty has persisted as a key factor in causing these situations. Homelessness was not however viewed as a ‘social problem’ in Ireland until relatively recently (O’Sullivan, 1996). Both national and international research over the last decade indicates that the population of homeless is growing and its composition changing. This has led to the identification of the so called ‘new homeless’, as a population increasingly made up of a constantly changing group of vulnerable individuals often with complex needs.

In this Chapter the available literature on homelessness will be reviewed. The first section attempts to define what is meant by homelessness and how it may be measured. Thereafter, contemporary theories of the phenomenon are outlined in an attempt to examine possible causes of homelessness. The characteristics of homeless people are then presented. It will be seen that the homeless population are not a homogenous group, and similarly that the experience of homelessness is not evenly distributed across the general population. Rather it is very clearly socially patterned. This is followed by a section, which situates homelessness in the Irish context. Here the available information on the nature, extent and policy responses to homelessness in Ireland is outlined. Finally, homelessness among the drug using population is examined. It will be seen that there is a dearth of research concerned with homelessness among this sub-group. The research that is available indicates that homelessness can have an adverse effect on drug users injecting risk behaviour and exacerbate their drug use. The Chapter concludes with a review of this literature on drug use and homelessness and its implications for risk behaviour.

## 2.2 DEFINING HOMELESSNESS

There is no generally agreed definition of homelessness; different people use the word in substantially different ways. Greve (1991) suggests that the main reason for this is that whatever definition adopted will have clear policy implications. For example, there is reluctance on the part of government departments to employ a broad definition of homelessness, as it would require them to accept greater responsibility for housing and homelessness. Carlen (1996) argues that the struggle over the meaning of homelessness is integral both to the governance of homelessness itself and to the more fundamental management of social change. The narrowest possible definition is that of literally being roofless, the total lack of any possible shelter. But in reality the term 'home' has come to have cultural and ideological meanings that goes way beyond merely having a roof over one's head. Watson and Austerberry (1986) in theorising homelessness argue that one of the main problems with the concept of homelessness is the notion of 'home'. A house is generally taken to be synonymous with a dwelling or physical structure, whereas Watson and Austerberry argue that a home implies particular social relations - traditionally the nuclear family.

The importance of a home, or a residential address cannot be over-estimated. It has become the major point of reference, accountability and delivery for welfare. Furthermore, an address is required for voting, it is necessary for getting any kind of credit, and it is a desirable prerequisite for obtaining bail on criminal charges. Carlen (1996) argues that the belief in the power of residency for disciplinary accountability is in fact so strong that numerous attempts have been made to incorporate the power of domestic residency into the formal penal sphere as a means of strengthening its surveillance of offenders. For example, curfews and electronic monitoring are all examples of attempts to convert home into a prison. Thus, the meaning of 'home' is central to developing a full understanding of homelessness. Without understanding the concept of 'home' in the conventional and material sense it is impossible to understand why a variety of 'homeless' people find themselves without a 'home' and are stigmatized as being homeless.

Carlen (1996) identifies four possible meanings of home, firstly there is literally *home as shelter* in the physical sense; secondly *home as consumption*, the place of domesticity which is either owned or rented, and where material goods of both economic and symbolic value are contained. Thirdly there is *home as emotional retreat* as in a place where one belongs, and fourthly there are *homes* as in children's homes, the statutory shelters provided by the state. Similarly, Carlen (1996) argues that the meaning of 'homelessness' is complex and multidimensional. Firstly, there is homelessness as literally the *lack of home* according to any of the above definitions; in addition, there is *homelessness as legitimated housing needs* according to a mix of moral, economic, legal, ideological and political interests. Lastly, Carlen (1996) identifies, 'homelessness' as a catchall metaphor for a variety of poverty-stricken or otherwise socially questionable conditions.

In a US study of homelessness Rossi *et al* (1987) divided the homeless into two groups; firstly, the *literal* homeless, defined as those individuals who clearly do not have access to a conventional dwelling and who would be homeless by any conceivable definition of the term. Secondly, the *marginally housed*, are those individuals with tenuous or temporary housing of more or less marginal adequacy. On the other hand, Watson and Austerberry (1986) suggest that homelessness should be understood on the basis of a house to homelessness continuum, with literal rooflessness or sleeping rough, at one extreme, and absolute security of tenure at the other. Temporary accommodation, such as hostels, squats and insecure rental would come in between. Watson and Austerberry (1986) argue that adopting such a continuum enables the use of such categories as 'potential homelessness' pertaining to, for example, all inmates of institutions such as hospitals who could and would live outside if appropriate permanent accommodation were to be made available, and who would therefore require

accommodation if they were turned out of the institutions. As Watson and Austerberry (1986) are concerned with *degrees* of homelessness, their definition offers a quantitative approach to measuring homelessness. Similarly, Redburn and Buss (1986) argue that homelessness is not an absolute condition rather a series of deprivations of varying degrees.

On the other hand, Jahile (1987) offers a more qualitative definition of homelessness, by distinguishing between the subjective and objective dimensions of homelessness, and the differences in housing needs. Jahile (1987) identifies what he refers to as '*benign homelessness*', when a person is temporarily homeless but actually has the personal, social and material resources to be housed fairly speedily when required; and '*malign homelessness*' when a person is homeless and has either no or insufficient access to the resources necessary to reverse the situation. This qualitative distinction allows for differences between people living in the same conditions, for example, differences between people living in the same hostel but under different circumstances.

Homelessness in the UK is often described along the lines of homelessness legislation. The main elements of current homelessness legislation in the UK first appeared on the statute books with the Housing (Homeless Persons) Act 1977. Later incorporated into Part III of the Housing Act 1985, this gave legal definitions of the homeless and 'priority needs'<sup>3</sup>. According to the legislation

“Someone is homeless if there is no accommodation in the United Kingdom or else where which this person can reasonably occupy together with anyone else who normally lives with them as a member of their family or in circumstances in which it is reasonable for that person to do so”.

In the UK those individuals considered homeless in accordance with the legislation, and who qualify for assistance are called the *statutory homeless*. Conversely, the *non-statutory homeless* are those who cannot get access to accommodation because they fall outside the groups specified by the relevant legislation. This group of homeless is largely made up of single people without children who do not qualify for assistance because they are not considered 'priority needs' or 'vulnerable' under the terms of the legislation and is generally referred to as single homeless people.

Categories of homelessness are also frequently employed that differentiate on the basis of the nature of homelessness itself. For example, O'Sullivan (1996) in categorising homelessness distinguishes between the visible homeless, the hidden homeless and those at risk of homelessness. Accordingly, the *visible homeless*, are those individuals who are homeless, living in shelters or other forms of emergency accommodation, and those who are shelterless or rough sleepers. The *hidden homeless* are usually defined as being

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<sup>3</sup> 'Priority needs' apply to the following; those who are pregnant, or who live in a household with someone who is pregnant; those who live in a household that contains one or more dependent child and; those who live in a household that contains a person who is 'vulnerable'. Those who are vulnerable include; people who find it difficult to fend for themselves due to old age; people with learning difficulties; people with mental health problems; disabled people and young people 'at risk'. The legislation has been criticised for not including people with drugs and/or alcohol dependencies, ex-offenders, and people with HIV/AIDS and other terminal illnesses, as 'vulnerable' (Pleace et al, 1997).

“people who are living in insecure accommodation and who are regarded as either a concealed or as a potential household. Concealed households are those that share accommodation with at least one other household. Potential households are those in which a concealed household or a member or members of an existing household wish to live separately”. (Pleace *et al*, 1997:7)

There are a number of problems with the concept of hidden homeless, the main one being that it can be applied to almost any form of housing need. Pleace *et al* (1997) argue that this can result in all housing needs being referred to as a form of homelessness, which may result in the unique nature and distress of actual homelessness becoming lost. Moreover, it raises the question whether being poorly housed, is the same as having nowhere to live. The final category is *individuals at risk of homelessness*. This refers to individuals who are currently housed, but are likely to become homeless as a result of economic difficulties, high rent, or insecurity of tenure (O’Sullivan, 1996).

In the UK the Department of Environment’s 1981 study *Single and Homeless* was one of the first, at a statutory level, to utilise a very broad definition of homelessness. They employed an index incorporating the so called ‘hidden homeless’ (often only in so far as they are not otherwise recognised as homeless) - as well as the ‘visible, or literally roofless homeless’. The ‘homeless’ in their research is defined as persons

- ♣ being without shelter;
- ♣ facing the loss of shelter within one month;
- ♣ living in a situation of no security of tenure and being forced to seek alternative accommodation within a time period which the individual considers to be immediate; for example; potential discharge from institutions of all types;
- ♣ people living with friends or relatives in overcrowded conditions; or illegal tenancies and;
- ♣ living in reception centres, crash pads, derelict buildings, squats, hostels, cheap lodgings, cheap hotels, and boarding houses.

It has been shown that no single definition of home can be considered absolute, because the meaning is relative and varies historically across different regions and/or societies (Watson and Austerberry, 1986). Furthermore, at its most basic level, home for an individual is shaped by the individual’s understanding of the concept. Consequently, individuals can be roofless and yet maintain that they are not homeless. The difficulty and ambiguity over defining homelessness has led some researchers (e.g. Passaro, 1996) to use the term ‘houseless’ instead.

## 2.3 MEASURING HOMELESSNESS

It is clearly important to have accurate information on the extent and number of individuals who are homeless. However, the lack of consensus about what exactly constitutes homelessness as outlined in the previous section, and the distinctions made between the types of homelessness - such as statutory or non-statutory homelessness - causes immense problems for measurement. One of the main problems with measurement is that the homeless population is constantly in a state of flux. Some

people experience homelessness for years, but many experience it periodically or enter the homeless population for a period and then leave it (Anderson *et al*, 1993). Most of the data available on homelessness underestimates the extent of the problem. For example, the statutory returns made by local authorities, while accounting for the bulk of the homeless, only provides information on those who have been bureaucratically accepted and defined as being homeless. Moreover, this data needs to be treated with caution as it is collected on households rather than on individuals. Other methods employed to determine the extent of 'types' of homelessness such as rough sleepers have also limited value. For example, a head count of the number of rough sleepers over one or two nights, obviously provides an imprecise snapshot of the number of individuals sleeping rough, and cannot hope to represent the actual number of people sleeping in such conditions. The number of people sleeping rough during a specific year will inevitably exceed the number sleeping rough on any given night. Similarly, there are problems associated with data collected from a hostel head count as such a method is at risk of duplication, misrepresentation, overestimation or unintentional exclusion of members of the homeless population (Williams and O'Connor, 1999). In short, various methods have been employed to attempt to measure the extent of homelessness. While such data has its limitations, it is nonetheless valuable in providing some insight into the nature and extent of homelessness.

## 2.4 CAUSES OF HOMELESSNESS

There is no universal consensus on why certain people become homeless. Traditionally there are two broad explanations of homelessness, one, which emphasises the personal problems of the individual who is homeless and a second which emphasises structural causes of homelessness. The former usually referred to as the agency approach to homelessness can be divided into two strands. Firstly, individuals are responsible for their own homelessness. This can be seen as a victim-blame approach and it usually evokes a minimalist response such as the provision of basic accommodation (Neale, 1997). The alternative individual explanation of homelessness maintains that people become homeless because of a personal inadequacy or failing, for which they cannot be held entirely responsible. For example, a personal problem such as mental illness or alcohol use renders the individual unable to maintain permanent housing. The high estimates of mental illness among homeless populations (as high as 90% in one study, Bassuk *et al* 1984) reinforce such views.

The focus on individual factors has often deflected attention from the structural conditions, which allow individuals, and groups to become seriously disadvantaged and homeless. To this end, some argue that structural factors such as poor economic and social conditions must exist for even the most vulnerable sections of the population, such as the mentally ill, to become homeless. According to this view, a large and growing 'new homeless' population has resulted from structural problems such as small stocks of low-cost housing, high unemployment and high levels of poverty. The main structural factors, which are seen to cause homelessness, are as follows.

- ▲ *Increased gap between incomes and the price of housing*: In the 1990's housing prices have more than doubled, while incomes have failed to increase at the same rate. Over the same period there has also been a widening inequality of incomes.
- ▲ *Poverty and Inequality*: Against the backdrop of the current economic boom, poverty remains a persistent feature of Irish society. The Central Statistics Office and the E.S.R.I. have documented the worsening levels of poverty in the country. According to their findings, in 1994 18.5% of the households - representing 20.7% of the population - fall below the income poverty line set at 50% of the average household income (Callan *et al*, 1996).
- ▲ *Decrease in the number of housing units available for renting*. Over the years there has been a decline in the availability of homes to rent, for three main reasons;
  - i. A drop in the number of houses being built by local authorities;

- ii. The introduction of the 'Right to Buy' policy which has depleted social housing stock;
- iii. The reduction in the number of private dwellings available for rent.

All of which has resulted in a decline in the opportunities available in the private rented sector, that part of the housing market which according to (Harvey and Higgins, 1989) has "traditionally provided accommodation for the poor, the young, the mobile and the old".

The structural causes of homelessness described above exist independently of any individual awareness of them. Moreover, as Carlen (1996) argues they frequently remain obscure to people even after they have become homeless.

On the other hand Blackwell (1995) divides the causes of homelessness into economic reasons and social reasons. Economic reasons include immediate causes such as, eviction, increases in rent and rent arrears in addition to more fundamental causes such as, the lack of appropriate housing and the inability of individuals to exist on social welfare benefits. While social reasons include inadequate housing conditions, escape from conflict in the home and marital breakdown. Research in the US supports this hypothesis. For example, Elliott and Krivo (1991) argue that unfavourable structural conditions are a necessary precursor to homelessness, regardless of the extent of personal problems among those negatively affected by them. They tested the effects of four structural conditions on the rates of homelessness in U.S. metropolitan areas in late 1993 and early 1994. They identified four structural factors that relate to high rates of homelessness, unavailable low-cost housing, high poverty, poor economic conditions and lack of mental health care facilities. Elliott and Krivo (1991) found that the strongest relationship was between homelessness and low-cost housing. They concluded that when low-cost housing is less available, structural limits are placed on the ability of individuals to find and keep housing. This in turn results in some individuals being shut out of the renter's market and left in the streets. However, Elliott and Krivo (1991) also recognise that under unfavourable structural conditions, those suffering from personal problems may be the most vulnerable to becoming homeless. As a result, personal problems including mental illness may be widespread among the homeless.

As illustrated the various theories of homelessness are in many respects inadequate. A more comprehensive theoretical understanding of the needs and circumstances of the homeless is needed in order to improve service provision. As Neale (1997) argues "good practice is more likely to result from good theory than from poor or inadequate explanations" of homelessness. To conclude, individuals do not cause their own homelessness and it is therefore unacceptable to leave them to their own devices when housing and support networks fail. In order to attempt to effect positive change in service provision for the homeless, an increased understanding of the relationship between homelessness and social theory is essential.

## 2.5 WHO ARE THE HOMELESS?

The traditional perceptions of the homeless have been based on stereotypical images of the 'down-and-out'. International research illustrates that the homeless population does not conform to such images. The homeless are not a homogenous group; they include families, single persons, and increasingly women and persons aged under forty (Anderson, *et al.* 1993; Smith, 1999). The population also includes individuals living in hostels and night shelters and those sleeping rough. The lack of consensus on who is categorised as being 'homeless' is, as illustrated previously, largely dependent on definitional issues around the use of terminology.

Research in the UK (Deacon *et al.*, 1995) and Ireland (Williams, and O'Connor, 1999) suggests that the number of single homeless people is increasing. The gender composition of the population is also changing, in that research in recent years has highlighted increased homelessness among women. The results of Anderson *et al.* (1993) study suggest that the number of women who are non-statutorily homeless is significant and increasing. More recently, research in the UK found that a quarter of newly homeless young people arriving in London were women (Jones, 1999). This has been

paralleled by an increase in the number of young women using winter shelters who have slept rough. Research also suggests that the average age of the women in the homeless population is falling. Moreover, within the homeless population women as a whole are a much younger sub-group (Kemp, 1997).

Smith's (1999) criticism of research in the UK is that the picture derived from studies of single homelessness is highly gendered. A common explanation of why women are under-represented in homeless surveys has been that these women, are not approaching homeless agencies, and consequently make up the category identified as the 'hidden homeless' (Greve, 1991). Smith (1999) argues that both surveys of single homeless and qualitative studies using indepth interviews primarily involve individuals living in hostels, squats, sleeping rough or attending soup-runs. Fewer single homeless women are found in these situations, as they are more likely to be staying with friends and relatives. On the other hand, Smith (1999) points out that young homeless women in the UK, even single homeless women, are more likely to report as homeless to local authority housing departments or housing associations, and these agencies are not generally used as sample sites to contact homeless young single people. Smith *et al* (1996) survey of over 15,000 young people who were clients of housing and homeless agencies found that approximately half of the young homeless in any city were women<sup>4</sup>. Smith (1999) argues the reason for the different gender pattern found in this survey was that all young housing clients of any domestic or parenting status were included and that information was collected from all types of housing and homeless agencies – including housing departments and housing association.

As discussed previously there are considerable methodological difficulties in attempting to undertake representative surveys of the homeless. Regardless, the diversity of the homeless population in the UK is highlighted most clearly by the 1991 survey *Single Homeless People* (Anderson *et al*, 1993) which compares the characteristics of individuals staying in emergency accommodation with rough sleepers. In this study a representative sample of 1,346 people staying in hostels, night shelters, and B&B's were interviewed. Interviews were also conducted with 507 people sleeping rough, who were largely characterised by poor health status, and who represented the worst extreme of homelessness.

Anderson *et al's* (1993) research illustrates that the homeless population is not a homogenous group, as significant differences were found between rough sleepers and people staying in emergency accommodation (e.g. hostels and B&B's). For example, gender differences revealed that although women are underrepresented among the homeless population they are significantly less likely to be sleeping rough than staying in hostels and B&B's. Other notable differences between rough sleepers and those staying in emergency accommodation included age. Individuals who were staying in hostels and B&B's were more likely than rough sleepers to be either young adults or - to a lesser extent - elderly (Kemp, 1997). Thirty percent of people in emergency accommodation were under the age of 25 years compared with 16% of those sleeping rough. There were also significant age differences between homeless men and women, both among those staying in emergency accommodation and those sleeping rough. For example, among the rough sleeping sample, women were substantially younger than their male counterparts. In that 44% of the women were aged under 25 years compared with only 13% of the men (Kemp, 1997). Kemp (1997) also compared the findings of the 1991 survey regarding those staying in hostels and B&B's with the results of the 1972 study by Digby (1976) of hostels and lodgings houses. This comparison revealed some major changes in characteristics of the homeless population over time, most notably, an increase in the number of women, young people and black people living in such emergency accommodation (Kemp, 1997).

Research also reveals that the single homeless population suffers from a range of other forms of social deprivation, exclusion and discrimination. The majority of single homeless people are long-term unemployed (Quilgars, and Anderson, 1997), and in addition they are more likely than the general population to have prior experiences of institutions - such as children's homes and prisons (Carlen, 1996). Furthermore, numerous research studies have illustrated that the homeless suffer worse health

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<sup>4</sup> The information for this study was collected over a three-month period, in seven cities spread across Britain (Leeds, Liverpool, Manchester, Birmingham, Bristol, Cardiff and Glasgow).



than the general population (Bines, 1997). The exact relationship between health and homelessness is unclear, this is because some health problems (in particular mental health problems), may sometimes predate or even lead to homelessness as well as being caused or exacerbated by experiences of homelessness. However, international research has shown that the physical and mental health of homeless people is considerably worse than that of the general population (Bines, 1997; Anderson *et al* 1993). Homeless people face an increased risk of physical health problems because of poor diet, stress, cold, and damp and overcrowded conditions. At the same time homeless people face an increased risk of mental health problems. Primarily because, they are subject not only to the stress of the factors that made them homeless, but also the experiences of being homeless which can adversely affect their mental health.

Despite the fact that the homeless population is not comprised of a homogenous group, there are many common concerns for them. Issues of difference, individuality, subjectivity and personal experience should therefore be recognised, but without neglecting the shared experiences of this group (Neale, 1997).

## 2.6 HOMELESSNESS IN IRELAND

As illustrated previously, homelessness is inextricably linked with housing policy, in that, the provision of suitable housing is central to a successful strategy for tackling homelessness. Until the 1980's homeless people were at best seen as a marginal concern to the Irish administrative and political system and were not regarded as a priority in local authorities housing allocation policies (Harvey, 1995). In this section, homelessness in Ireland is examined by, firstly, briefly reviewing Irish housing policy, and thereafter, examining the available literature on the extent and nature of the Irish homeless population.

Homelessness has only recently been recognised as a significant 'social problem' in Ireland. Traditionally, Irish housing policy has not been concerned with the problem of homelessness, and the housing authorities were not seen as having a role to play in dealing with the problem. Moreover, some local authorities refused to deal with homeless people at all (Harvey, 1983). Homelessness was not in fact the responsibility of the housing authorities, falling instead to the health boards, although as Blackwell (1995) argues in practice responsibility was not clearly assigned to either. Under Section 44 of the 1966 Housing Act the local authorities did have responsibility for providing

“for the accommodation of persons who are in need of housing on medical, compassionate or similar grounds if the circumstances of the persons would not permit them to be otherwise housed”.

It was not until the introduction of the Housing Act 1988 that Irish housing legislation explicitly referred to the needs of the homeless (Kelleher, 1990). Under section 2 of the 1988 Act a person is regarded as being homeless by the relevant housing authorities if;

- (a) there is no accommodation available, which in the opinion of the authorities, he, together with any other person who normally resides with him or who might reasonably be 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 Housing Act 1988 was a result of a seven-year campaign by non-government organisations to end the criminalisation<sup>5</sup> and exclusion of homeless people from the national housing system. The legislation is partially successful in this regard.

As a result of the Housing Act 1988, housing authorities are obliged to assess the needs of homeless people for local authority accommodation at least every three years, to ensure that this need is adequately met, to have regard for the extent of homelessness and to undertake planning to provide for the needs of homeless people. Under Section 10, housing authorities can avail of new powers to meet the needs of the homeless. However, Williams and O'Connor (1999) argue that the results of the four assessments undertaken between 1989 and 1996 had little practical impact on the development of services for homeless people. This was primarily due to their concentration on housing provision as opposed to the planning of homeless services. In addition, the unreliability of assessments due to an inadequate methodology combined with a lack of resources and support available to local authorities prevented any development.

In 1990 Focus Point conducted a research project to examine and monitor the implementation of the Housing Act of 1988 with specific reference to “the changes introduced in policies and practices relevant to homeless people” (Kelleher, 1990). It illustrated that only minimum changes had taken place, which had any direct benefit to homeless people. The study argued that improved co-operation between voluntary and statutory service providers would contribute to improved service provision, planning and development. Moreover, the study highlighted the need for the development of an in-depth methodology to examine the extent and assess the needs of homeless people. Likewise in 1992, the National Campaign for the Homeless in Ireland commissioned NEXUS to undertake research on the effectiveness of the Housing Act. It illustrated that local authorities could identify only 157 homeless people that were specifically housed as a direct result of the Act. In addition, the findings of the research suggested that there were varying degrees of priority with which each local housing authority responded to the homeless. Harvey (1995) argues that research undertaken on the operation of the Act reveals weaknesses in planning, organisation and inadequate allocation of resources.

Little empirical data is available on the number of homeless people in Ireland. Current estimates include only those in the most ‘deprived group’ who are ‘houseless’ and does not include those who may be threatened with eviction in the private-letting sector, families who share accommodation with another family, those living in hostels, those who are about to be released from institutions (such as prisons) nor does it include travellers. In accordance with the requirements of the 1988 Housing Act, assessments of the homeless population were undertaken in 1989, 1991, 1993 and 1996 with national returns of 1,491, 2,371, 2,172 and 2,501 respectively. The 1999 assessment of homelessness in Dublin, Kildare and Wicklow which was prepared by the Economic and Social Research Institute (ESRI) on behalf of the Homeless Initiative has being regarded as the most significant development to date. This assessment identified 2,900 adults and a total of 990 dependent children who were homeless in Counties Dublin, Kildare and Wicklow during the week of the survey. Research was undertaken by means of an extensive survey administered in the various agencies and organisations providing services to the homeless in the week ending 31<sup>st</sup> March 1999. These were characterised into two groups- those who used homeless services during the week (1,350) and those who were accepted as homeless by a local authority but who did not have contact with any service during the week (1,550).

Outside the Greater Dublin area few prevalence studies have been carried out. One survey conducted by the Department of Applied Social Studies at University College Cork, estimated about 300 people homeless in the city<sup>6</sup>. While, the first major report on homelessness in an urban centre outside Dublin has found that an estimated 963 people were classified as homeless at some stage in Galway city in 1998<sup>7</sup>. Since these figures represent a count for the whole year, they cannot be compared directly with

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<sup>5</sup> Under the Vagrancy Act homelessness was a criminal offense, this Act was not repealed until the 1988 Housing Act.

<sup>6</sup> “Little Hope for growing Homeless” in Irish Times, September 11, 1999.

<sup>7</sup> “Report on Plight of Galway Homeless” in Irish Times, July 8, 1999 – Reporting on MacNeela (1998) Report “Homelessness in Galway”

those from Dublin and Cork, which provide only a “snapshot” of the situation. In any methodology employed to estimate homelessness it is important to bear in mind the transient nature of population, in that the number of people who experience homelessness at some point in time, is far greater than the number of people who are currently homeless.

Although numerous policy documents and research studies have been undertaken to examine homelessness in Ireland, they have tended to be highly localised and concentrate on specific personal characteristics of the homeless population. For example, Holohan (1997) provided empirical information about the health of the homeless population of Dublin. In addition, there has also been research undertaken regarding the relationship between mental health and homelessness. Cleary and Prizeman (1998) examined the association between mental illness and homelessness in an attempt to identify individual characteristics that may be risk factors for homelessness. However, some have argued that homelessness is itself a risk factor for emotional disorder. For example, Goodman *et al* (1991) use the construct of psychological trauma as a means of understanding the potential effects of homelessness on individuals. They argue that the event of becoming homeless or the loss of stable shelter sudden or gradual may produce symptoms of psychological trauma.

There is however little quantitative data available on the characteristics of homeless people in Ireland. Holohan’s (1997) study on health status and health service utilisation among the homeless in Dublin illustrates some general baseline data on the homeless population. Almost two-thirds of the sample were under the age of 45 while only 8% were over the age of 65 years. Eighty five percent of the homeless population was male. The proportion of females with dependents was greater than the corresponding proportion for males. Furthermore, the average number of dependent children was greater among females than males. At the time of interview, forty five percent of the homeless respondents had been homeless for more than one year while a further 34% had been homeless for between one and twelve months. Forty percent of respondents had been homeless at least once in the past with a mean number of episodes of 3.9.

Holohan’s study (1997) revealed that the combined prevalence of all physical and psychiatric complaints among his sample was 65.7%. High levels of alcoholism, mental illness, extreme poverty and social isolation have been found in other studies of the homeless in Ireland (Cleary and Prizeman, 1998; Holohan, 1997; O’Sullivan 1996). Homeless persons are by the nature of their lifestyle at increased risk of experiencing health problems, both physical and psychiatric. For example, Cleary and Prizeman (1998) reported that three quarters of the homeless respondents interviewed reported that they had experienced some mental health problems. Twenty five percent of the sample was in contact with psychiatric services and three quarters of these attended a service at least once a month. While 12% of those interviewed never had a job and of those who had previous experience of employment, 58% of interviewees had not worked in over a year.

The ESRI report *Counted In* (Williams and O’Connor, 1999) contains some vital information on the homeless population. Accordingly, 36% of the population were female. The average age of the homeless male was 39 years, while women were on average 32 years of age. According to their findings, 12% of the population were under 20 years, a further 17% were aged between 21 and 25, 26% were between 26 and 35 years, the remaining 45% were over 35 years of age. However, homeless females were more likely than their male counterparts to be in the younger age cohorts. For example, 19% of the homeless females were under 20 years, compared with only 8% of the homeless males. Regarding length of time homeless, 8% of the population were homeless for less than one month; 10% between one and three months; 11% were homeless for between 3 to 6 months. A further 34% were homeless for between 1 and 5 years, and 14% were homeless for over 5 years. Some gender differences were discovered in the data, in that women were more likely to be homeless for shorter periods than men (Williams and O’Connor 1999).

To conclude, for the first time in Irish housing legislation the 1988 Housing Act specifically addressed the needs of homeless people. As a result of the Act the housing authorities have now the main co-ordinating role for ensuring that the needs of homeless people are met. (Kelleher, 1990). They are obliged to assess the need of homeless people for local authority accommodation; ensure that this need is adequately addressed; have regard to the extent of homelessness and to undertake

planning to provide for the needs of homeless people. In order to ensure adequate service provision for the homeless, it is necessary to carry out more quantitative and qualitative research on the population to identify needs thereby ensuring appropriate service provision.

## 2.7 DRUG USE AND HOMELESSNESS

Compared to the homeless population studies in the 1950s and 1960s the so called 'new homeless' of the 1980s and 1990s are not only more numerous but they are also more visible; they sleep in public places, and are not confined to particular areas of a city. Whereas, the homeless population from prior decades consisted primarily of older men, the current homeless are more heterogeneous. As previously outlined, they are younger, better educated, and more likely to be women. Alcohol-related problems have been predominantly reported in studies of homeless persons in the past decades (Fischer, and Breakey, 1991), while the contemporary generation of homeless individuals is also distinguished by reports of high rates of problem drug use (O'Flaherty, 1996)

This section critically analyses the available literature on drug use and homelessness. It will be seen that there is a vast amount of research - in particular US studies - concerned with homelessness and 'substance mis/use' (Schutt and Garrett, 1992). Such research combines alcohol and illicit drugs into one category. Although 'substance mis/use' is a commonly used term in the US, lumping both alcohol and drug users into a single category precludes making distinctions between these two very different groups. This is particularly unfortunate as there are social and clinical differences between alcohol and illicit drug users, that both researchers as well as service providers need to understand. In short, there is a paucity of literature, which concentrates specifically on drug use and homelessness.

Moreover, the research, which does exist focuses primarily on the extent of drug use among the homeless population, while what is of particular concern in this study, is the extent of homelessness among the drug using population. Consequently, much of the research that will be reviewed in this chapter is 'drug research', or research concerned with drug users, as opposed to studies of the homeless population. The main problem with this 'drug research' is that many of these studies only treat accommodation as a demographic variable, thus, homelessness is rarely examined in any great detail. However, as will be illustrated, some valuable information is available which illustrates the consequences of 'homelessness' on drug users injecting (Cox and Lawless, 1999) and sexual risk behaviour (Rosenthal *et al*, 1994; Rotheram-Borus *et al*, 1991). Although, in this section the relationship between drug use and homelessness is examined in part, it is not intended to provide a causal explanation for homelessness among drug users.

### PREVALENCE

The reported prevalence of alcohol and drug use among the homeless varies dramatically depending on the sample, the definitions of alcoholism, drug use, and homelessness, the setting (rough sleepers, or those staying in hostels) and finally the methods and assessment tools used. Regardless, alcohol use is considered one of the most pervasive health problems among the homeless (Garrett, 1989; Mulkern, and Spencer, 1994). Reported rates of alcohol use among the homeless range from 4% to 86% (Frischer, 1989). Credible estimates of the prevalence of alcoholism among the homeless in the US suggest that it effects 30% to 40% of the homeless population (McCarthy *et al*, 1991). Some researchers suggest that the magnitude of alcohol problems can best be appreciated by comparisons with rates described for the general population. According to this methodology, prevalence rates among the homeless population are 6 to 7 times greater than would be expected in the general population (Frischer and Breakey, 1991).

Among the homeless, men are more likely to report alcohol and drug related problems, whereas higher rates of mental illness are reported among women. Wright and Weber (1987) found that 47% of the homeless men in their study and 16% of the homeless women could be classified as problem drinkers. Although women were less likely to have alcohol-related problems, in Wright and Weber's

study the rates of drug use were relatively similar among men (11%) and women (9%). The strongest correlate of drug use found by Wright (1998) was age; rates of drug use were greatest among younger homeless persons and decreased with age. Although surveys of homeless populations have found consistently high rates of alcohol use, particularly among single men, recent research have called the results of these studies into question. In short, the studies that produced high prevalence rates greatly over-represented long-term shelter users and single men. In addition, lifetime rather than current measures of 'addiction' were employed (McCarty *et al*, 1991).

Research on alcohol use among the homeless also suggests that homeless alcohol users experience more severe forms of alcoholism than domiciled alcoholics. In other words, they exhibit more severe patterns of drinking as measured by duration, regularity, frequency, amount and symptoms of dependence (Koegel and Burman, 1988). Alcoholism and the behaviours associated with it, particularly in the homeless population have a major impact on physical health. Wright *et al* (1987) found that homeless alcohol users were more likely to suffer from liver disease, seizure disorders or other neurological impairments, to have various nutritional deficiencies and to suffer from hypertension. Alcohol use has also been identified as one of the single greatest risk factors for arrest among the homeless population (Frischer and Breakey, 1991).

As previously stated, information on the prevalence and consequences of drug use among the homeless is not nearly as extensive as findings on alcohol use. While there is intuitively a relationship between drug use and homelessness, very little work has been conducted to test this relationship (O'Higgins, 1998). Hammersley and Pearl's (1997) study illustrates that among homeless young people in Glasgow, housing issues and drug problems were intimately related. In the Glasgow study 100 homeless young people were interviewed in a homeless project. The findings revealed that over three-quarters had used cannabis, hallucinogens or amphetamines and just under a half felt they had been addicted to these drugs. Flemen (1997) found very high levels of homelessness among new drug users attending a London drugs service. Eighty four percent of the 1,221 drug users who presented at the Hungerford Drug Project between April 1995 and April 1996 were classified as being homeless. Moreover, 19% of clients reported sleeping rough at the time of interview. Flemen's (1997) study of drug use among young homeless people in London revealed that 88% of the sample (n=700) reported using illicit drugs. Findings from Carlen (1996) "Three Cities Project" also revealed high levels of drug use, in that 76% of the young homeless people interview used illegal drugs.

## DRUG RESEARCH

As mentioned earlier regarding the extent of homelessness among drug users, 'drug research' usually only treats current accommodation as a variable, with the sample normally consisting of drug users who are currently in treatment. For example Sheehan *et al's* (1988) study of 150 drug users who were seeking treatment for the first time in three London treatment agencies found that 26% of their sample lived in either unstable accommodation or were homeless. More specifically 11% of the 150 clients were either squatting or in hostel accommodation, 6% were living with friends or relatives, 1% were in prison, 7% had no fixed abode, and 1% were living in other unsuitable accommodation. According to the Irish National Drug Treatment Reporting System in 1996, only 2.4 percent of the Irish drug using population reported being homeless (Moran *et al*, 1997). This report no doubt underestimates the extent of homelessness among drug users as it is only concerned with drug users in contact with treatment services. Higher levels of homelessness were found in a study carried out in the Merchant's Quay Project. A survey of all new presenters at the Project's Health Promotion Unit revealed that 19% (n=246) of the client group were homeless. The higher levels of homelessness may largely be explained by the chaotic, unstable nature of the client group. Findings from this study also highlighted some of the consequences of individuals 'out of home' status on their drug use. For example, homeless clients were significantly more likely than their housed counterparts to report the recent sharing of injecting equipment (Cox and Lawless, 1999).

International research has illustrated that unstable housing conditions can lead to increased risk behaviour among injecting drug users. For example, Klee and Morris's (1995) study of poly-drug injectors revealed significant differences between those who inject in public places and non-street injectors. Their analysis revealed that those who injected in public places were significantly more likely to be homeless, consequently lacking the facilities to inject in private. Street injectors were not only more likely to lack permanent accommodation, they were also more likely to have close contact with other injectors, in that they were more likely to inject in the company of friends. Moreover, street injectors were at particular risk of passing on used injecting equipment, and using others' injecting equipment. Of the respondents who reported injecting in public places, 39 reported doing so in streets, parks and other open places. Thirty-eight named more sheltered environments such as pub toilets and cars. Twenty-one respondents reported injecting in both exposed and sheltered areas. These were however, not mutually exclusive categories. Klee and Morris found that those who injected in public places were more risk orientated. Social and drug related factors conveyed an overall higher level of risk activity. In short Klee and Morris's (1995) research suggests that drug users who inject in public places, the majority of whom are homeless, are disposed towards health risk behaviour. The lack of predictable safe and private places to inject, a chaotic and depressing life-style, together with enhanced dependence on peers, increase the tendency to engage in injecting risk behaviour.

Other research has shown that drug users living in temporary accommodation, are more likely to share accommodation with other drug injectors (Klee *et al*, 1992). Moreover, sharing with other injecting drug users creates a social environment that leads to the sharing of injecting equipment. Research has found higher rates of sharing among injectors in these circumstances (Magura *et al*, 1989). The social network of the drug users has been shown to be an important consideration in relation to HIV risk behaviour (Samuels, *et al* 1992). Research has shown that HIV risk behaviour is related to the group of individuals with whom these behaviours are shared. Donoghoe *et al* (1992) study of injecting drug users in the UK found that those drug injectors who reported recently sharing injecting equipment were significantly more likely to report living in unstable accommodation, such as squats, and hostels, than non-sharers. They also found that living with other injectors was strongly associated with sharing.

Based on the aforementioned research the quality of housing circumstances and in particular unstable accommodation have been linked with HIV risk behaviour, in particular syringe sharing. The link between lack of adequate housing and sharing of risk behaviour may be further compounded where injectors, out of necessity, share accommodation with friends. Injectors who live with other people, particularly other injectors have been shown to be more likely to share (Donoghoe, *et al*, 1992; Ross *et al*, 1994). People make choices and decisions within the context of particular constraints and possibilities.

## CAUSE OR CONSEQUENCE

As discussed previously, the causes of homelessness are multiple and interactive, and include both individual/agency, and societal/structural factors. Among individual factors, alcohol and increasingly drug use rank as the leading cause of homelessness, in many US studies. For example according to Wright and Weber (1987) more than half of the homeless respondents interviewed identified alcohol and drug use as a major factor, or the single most important factor leading to the loss of their housing. There is however a lack of knowledge around the nature of the relationship between homelessness and problem drug or alcohol use. Johnson *et al* (1997) argue that two alternative perspectives exist to explain the relationship between substance use and homelessness, firstly 'social selection', and secondly 'social adaptation'. The social selection or 'drift down' hypothesis contends that substance use is one of the main pathways into homelessness. Accordingly, homelessness is the end result of a series of events that are a consequence of the individual's substance use. In support of this hypothesis some studies have indicated that substance use places individuals at increased risk of homelessness. Alternatively, Johnson *et al* (1997) put forward the 'social adaptation' or social

causation hypothesis that alcohol and drug use are more likely to be a consequence of homelessness. Accordingly, the use of alcohol or drugs is a means of adapting to life on the streets.

The majority of research concerned with both homelessness and drug abuse has, as illustrated above, examined the incidence of drug use (or substance mis/use) within the homeless population, as opposed to drug users experiences of homelessness. An extensive literature search revealed a dearth of research in this area. This may be due to the fact that as discussed previously, homelessness among the age group predominantly engaged in illicit drug use (those under 25) is a fairly recent phenomenon. In addition to problems of defining what constitutes abuse of, or addiction to, legal or illegal substances, the figures on drug and alcohol use alone cannot address the more pressing concern - whether drug/alcohol use is a cause or an effect of homelessness and poverty. Clearly, on an individual basis, drug use can be either a cause or effect, or both, of homelessness. Nonetheless, the available literature provides a valuable insight into the growing problems of homelessness among drug users, and the consequences of being homeless on both their drug use and injecting and sexual risk behaviour.

## 2.8 CONCLUSION

In this chapter the complexities of homelessness, in terms of definition, measurement, and causality have been outlined. It has been seen that there is a large body of conceptual literature concerned with homelessness, some of which has been critiqued here. A review of this research highlights the fact that there is no single agreed cause of homelessness, a range of structural factors combined in some instances with individual factors contributes to the problem of 'homelessness'. Equally, homeless people cannot be classified as a homogenous group, as Neale (1997:48) states

“they occupy a range of different and shifting positions in relation to a wide variety of power structures - for example, gender, race, age, health, and the employment and housing market”.

Based on a review of the available literature the only categorical statement that can be made is that individuals do not cause their own homelessness. The logical follow-on from this, is that as they are not solely responsible for their homelessness they should not be left to their own devices when the system fails them.

The relationship between drug use, alcohol use and homelessness is complex, and probably bi-directional. Although alcohol and drug use can increase the risk of homelessness, displacement and loss of shelter can also increase the use of alcohol and illicit drugs. Moreover, in many cases, drug and alcohol use is neither the cause nor the consequence of homelessness, but rather a condition that was aggravated by the loss of housing. In short, drug use and homelessness are clearly interrelated, complicating and exacerbating one another.

# CHAPTER THREE

## METHODOLOGY

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This chapter examines the research methodology, which was adopted to achieve the objectives of the study. It details the research instruments, which were employed, and outlines the limitations of the research. As discussed in some detail in Chapter Two conducting research in the area of drug use and homelessness is problematic. This is primarily due to the lack of consensus around the definition of homelessness. Using statutory homeless as a definition is often considered too conservative, as it automatically excludes the so-called 'hidden homeless'. Conversely, employing a broad definition, which encompasses all housing needs, is often criticised for diminishing the seriousness of homelessness or more specifically 'houselessness'. The fact that there is no generally agreed definition of homelessness means that there are difficulties in determining the extent and nature of this social problem. In the case of this study, these difficulties are compounded by the fact that the respondents are not only homeless but they are also problem drug users.

### 3.1 RESEARCH METHOD

To reiterate, the aim of the study was to collect information on problem drug users who were classified as being homeless. To summarise, in this study the term 'problem drug user' refers to an individual who as a result of taking psychoactive drugs suffers medical, psychological or social complications. This term recognises that that illicit drug use can cause a range of problems among regular consumers. A relatively broad definition of homelessness was employed, in that, it refers to individuals who are currently staying in any of the following; hostels, B&B's, squats, sleeping rough or staying with friends or relatives. This definition has been utilised in other research studies (e.g. Flemen, 1997).

As mentioned in Chapter Two, there is a lack of research concerned with homelessness and drug use, and what has been undertaken tends to focus on drug use among the homeless. To the authors' knowledge, there has been no published Irish study to date, which has examined homelessness among drug users. Recognising the lack of research in this area, it was therefore impossible to adopt or utilise an established research instrument of known reliability. The authors decided a quantitative research method was the most appropriate. To this end two questionnaires were designed. Firstly a screening questionnaire, which was used to identify the clients of the Contact Centre who were deemed to be 'homeless' and as such eligible to complete the second, a more detailed questionnaire. This second questionnaire, a *Survey of Out of Home Drug Users*, was designed to collect detailed information from participants on the following domains; previous experience of homelessness, current accommodation, drug using history, current drug use, health and well-being and contact with services.

During the week February 8<sup>th</sup> to 12<sup>th</sup> 1999, all drug users who presented at the Contact Centre were informed that a study of homeless among drug users was being carried out in the Project. They were asked whether they would be willing to complete a short questionnaire - the screening questionnaires. All clients were informed that non-participation in study would in no way effect the service they would receive in the Project. Those individuals who upon completion of the screening questionnaire were deemed to be homeless were asked whether they would be interested in completing the more detailed *Survey of Out of Home Drug Users*. When appropriate an appointment was made for those who



agreed to return at the earliest possible date to complete the Survey in private. In many instances appointments were not kept, and in such cases if the clients returned to the Contact Centre, they were once again asked whether they were interested in completing the Survey. The setting within which the research was undertaken had both advantages and disadvantages. The relaxed “drop in” nature of the Contact Centre, allowed for more informal interaction, however, it also meant follow-up attendance was unpredictable.

## 3.2 RESEARCH INSTRUMENTS

This section outlines the research instruments, which were employed in the study. The following two instruments were designed;

- *Screening Questionnaire* - The purpose of the screening questionnaire was primarily, to identify those clients who are currently ‘homeless’ (i.e living in hostel’s, B&Bs, squatting, living with friends/ relatives, or sleeping rough) and therefore eligible to partake in the *Survey of Out of Home Drug Users*.
- *Survey of Out of Home Drug Users* - This survey was concerned only with those respondents who were homeless at the time of interview.

### 3.2.1 SCREENING QUESTIONNAIRE

*Population Characteristics:* As discussed in the previous chapter, both national and international literature has highlighted that the general characteristics of the homeless population are changing. To reiterate, the homeless population are getting younger, with women constituting a greater proportion of the population. Basic demographic data was collected on gender, date of birth, and age. However, little is known about the population of homeless problem drug users. In this regard, the screening questionnaire allowed a more detailed examination by collecting information from all clients on the following;

*Current Accommodation;* All respondents were asked where they were currently living, in order to assess whether they could be classified as being ‘homeless’. Clients were also asked how long they have been living in their current accommodation and whether they regard such accommodation as temporary or permanent.

*Experience of Homelessness:* While the screening questionnaire was designed primarily to identify clients who were currently homeless, it also afforded the opportunity to get information on drug users prior experiences of homelessness. Due to the transient nature of homelessness, it is important to recognise that respondents who reported being housed may have had previous experience of homelessness. All respondents were asked whether or not they have ever been forced to leave accommodation due to either; court order, vigilantism, pressure from landlord, tenants/ residents association or family. Clients were also asked whether they were ever in a situation where they had no alternative but to stay in either, a hostel, squat, sleep rough or with friends/relatives. This provides some basic information on respondents use of ‘homeless’ accommodation. When appropriate, respondents were also asked to state what they considered as being the main reasons for having had to previously stay in homeless accommodation. A more subjective means of examining the extent of homelessness was included by asking clients whether they considered themselves to be ‘homeless’. This provided a means of analysing whether individual experiences of being ‘out of home’ were classified as periods of homelessness.

### 3.2.2 SURVEY OF OUT OF HOME DRUG USERS

The *socio-demographic details* collected from all clients include information on gender, age and age left school. In addition, clients were asked whether they ever had paid employment and to state their primary and secondary sources of income, as a means of examining their present economic status. Present legal status and previous criminal activity was also included. Clients were asked whether they have ever spent any time in prison serving a sentence or on remand. Respondents current legal status was also ascertained.

*Sleeping Arrangements-* Clients were asked to state their current sleeping arrangements. This was included to illustrate that the homeless drug users as a group are not a homogenous population. Length of time living in current homeless accommodation was also included. Respondents were also asked whether they consider themselves to be 'homeless'. This was included as it was envisaged that it might influence the services they use. The suggestion being that individuals who do not see themselves as being homeless, may prove less likely to use services intended for the homeless. Since being out of home, clients were asked whether they had been the victim of a crime, committed a drug related or non-drug related crime or been harassed by the police. Respondents were also asked what were the main advantages and disadvantages of their current accommodation. Finally, clients were asked their ideal type of accommodation and what were the main factors preventing them from obtaining such accommodation. A checklist was provided to clients which comprised of the following factors; lack of housing, money problems, drug use, lack of help in finding accommodation, have not tried or are not welcome. Respondents who reported lack of help in finding accommodation were asked to tick whether they require advice/information, financial help, or drug treatment as a means of obtaining their ideal accommodation.

*History of Homelessness:* All respondents were asked to identify the last place they thought of as home, the main reason why they left home, length of time out of home, and whether this is their first experience of homelessness. By asking clients the length of time 'out of home' in addition to length of time living in current accommodation, it allows a more complete examination of their current sleeping arrangements, given the high mobility of clients not only in and out of homelessness but also across categories of homelessness. For those respondents who have previously experienced homelessness, they were asked the age they first became homeless, and the number of episodes of homelessness they have experienced and the longest period homeless. Clients were also asked to roughly estimate how many times they have stayed in either a hostel, B&B, with friends or relatives or slept rough. A similar question to that included on the screening questionnaire which focuses on whether clients had ever been forced to leave their accommodation due to; court order, told to go by landlord, vigilantism or pressure from tenants or family was also included.

*Drug Use-* Respondents were asked details of both their drug history and current drug using patterns. Regarding drug history, clients are asked at what age they first started using drugs. Respondents were then asked their current primary drug, route of administration and frequency of use. Clients were also asked whether they used any secondary drugs and if so whether they injected their secondary drug. As international research has demonstrated that the type of accommodation can influence injecting risk behavior, it was necessary to examine in some detail the injecting behaviour of clients. Respondents were asked to outline places of injecting such as, own residence, home of friends/family, park, public toilets or other open public places. They were also asked whether they injected on their own, with partner, in a group or with friends. Recognising that with whom they inject, also influences the sharing and lending of injecting equipment and injecting paraphernalia, an examination of such activity in the four weeks prior to interview was also included. Respondents were asked to subjectively determine whether being 'homeless' changed either their drug use or injecting behaviour in any way. Respondents were also asked about the frequency of alcohol use and type of alcohol consumed.

*Health and Well-Being-* In this section, both the physical and mental health of respondents was examined in addition to sexual risk behaviour. Clients were asked whether they were sexually active and whether they had a regular partner. Respondents who reported being sexually active were asked

their use of condoms. An attempt was made to get a global assessment of both clients' physical and mental health. To this end, clients were asked to rate their physical and mental health on a five-point scale ranging from 'very good' to 'very poor'. More specific health complaints were also addressed, as respondents were asked whether they have complained of any of these complaints within the last three months. An open-ended question was also included asking clients whether they suffered from any other physical or mental health complaint not already covered. Respondents were also asked whether their health had changed in any way since being out of home and if so, how.

*Contact with Services-* Respondents were asked how long they have been attending the Merchant's Quay Project and more specifically what services within the Project have they been using. Current attendance at any drug treatment service, apart from the Merchants Quay Project was also included in order to ascertain general contact with drug services. Previous attendance at other services was also examined. In order to examine level of contact with medical services, it was necessary to firstly ask clients whether they were in receipt of a medical card. Contact with G.P, dentist, casualty or other medical services were also asked of clients. As already mentioned, contact with homeless services is highly influenced by whether clients consider themselves to be 'homeless'. In addition, clients use of homeless services differs according to type of homeless accommodation of clients. A checklist featuring homeless services located in the vicinity of the Merchant's Quay Project is included to ascertain current use of services.

All information collected was based on respondents self reported behaviour. It is possible that drug users may provide inaccurate information about their past and current behaviour. On the one hand, the respondents may be able to recall past behaviour. Moreover, as behaviour changes over time, it may be difficult for respondents to recall behaviour accurately. Conversely respondents may be unwilling to reveal drug using practices that are illegal (Siegel *et al*, 1986). Be it deliberate or unintentional self reported information about sensitive behaviour such as drug use can bias results. Nevertheless, a variety of approaches have shown that injecting drug users provide reasonably accurate reports of drug use (McElrath *et al*, 1994) and sexual behaviour (Kleun *et al*, 1994). Furthermore, efforts were taken to minimise recall bias by limiting the recall time periods to four weeks and three months. Although most quantitative researchers are concerned with establishing that the results of a particular investigation can be generalized beyond the confines of the research location, this study was highly context bound as all participants were clients of the Contact Centre, and self selecting. In short, they were not representative of the total population of homeless drug users.

### 3.3 SUMMARY

In order to conduct the research on homeless drug users, a quantitative methodology was employed. To this end, two questionnaires were designed. The first, a screening questionnaire intended to identify those eligible to complete the second, a *Survey of Out of Home Drug Users*. Any research on homelessness is fraught with difficulties, in that the definitional problems encountered with both the terms 'home' and 'homelessness' allows a subjective meaning of the concepts to emerge, in that, the researcher can choose the definition best suited to the research study. In this chapter, the terms 'homelessness' and 'drug use' have been clearly outlined for the purpose of this study. However, the findings of this study cannot be generalized; they refer to a very specific group in that they are homeless drug users who present at the Merchant's Quay Project.

# CHAPTER FOUR

## SCREENING DATA

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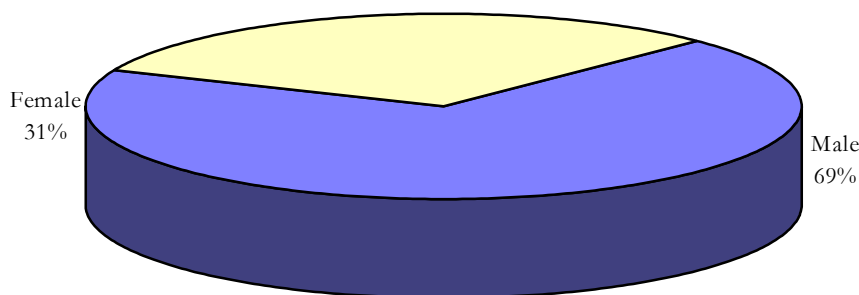
As discussed in Chapter Three, a screening questionnaire was designed to be administered to clients attending the Contact Centre, at the Merchant's Quay Project. The main purpose of the questionnaire was to examine the extent of homelessness among clients presenting at the Merchant's Quay Project. The use of the screening questionnaire permitted the identification of those clients who were currently 'homeless; - i.e. living in hostel's, B+B's, squatting, staying with friends and relatives or sleeping rough - and were therefore eligible to take part in the *Survey of Out of Home Drug Users*. However the questionnaire also provided valuable information on the number of clients who have ever experienced 'homelessness'.

During the week of the 8<sup>th</sup> to the 12<sup>th</sup> of February 1999, all clients who entered the Contact Centre at Merchant's Quay Project were asked whether they would complete the screening questionnaire. During this time period, a total of 190 active drug users agreed to fill-in the questionnaire. Based on the attendance figures for the month of February it was estimated that 75% of the clients who presented at the Contact Centre in the week in question completed the questionnaires<sup>8</sup>. In this chapter the data collected from the 190 screening questionnaires is presented.

### 4.1 POPULATION CHARACTERISTICS

**Figure 4.1** illustrates that of the 190 clients who participated in the completion of the screening questionnaire, 69% were male (n=131) and the remaining 31% were female (n=59).

**Figure 4.1 Gender of Clients**

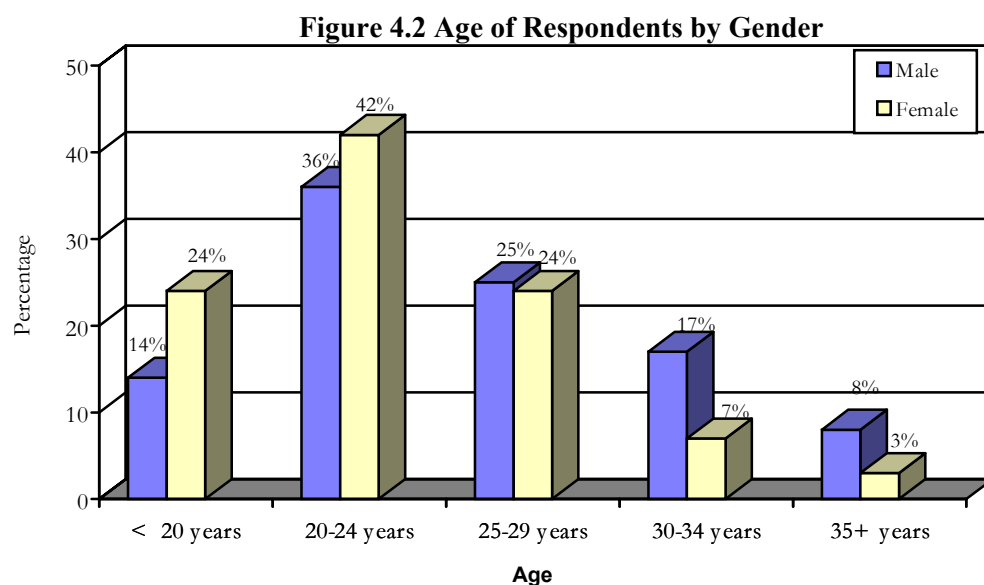


The average age of clients presenting at the Contact Centre was 24.9 years (range 16-43 years). Seventeen percent of the clients were teenagers; 61% were 25 years and under, and 80% of the clients were under thirty years of age. Analysis revealed that there were significant gender differences in the age of clients, in that female clients were significantly younger than their male counterparts ( $t$ -test =2.93;df=127; $p$ <0.01). The male clients were on average 25.7 years and female respondents were on

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<sup>8</sup> In February 1999 a total of 1016 clients attended the Merchant's Quay Project's Contact Centre. In that month the Project was open for 20 working days. Therefore, on average 51 clients attended on a daily basis- and an estimated 255 over the five days under investigation.

average 23.2 years of age. **Figure 4.2** graphically illustrates the gender differences in the age of clients. It illustrates that the female respondents were proportionately more likely than their male counterparts to be teenagers. Conversely, the male respondents were proportionately more likely to be over the age of 30 years.



#### 4.2 CURRENT ACCOMMODATION

All respondents were asked where they are currently living. As discussed previously, based on an individual's current accommodation they were deemed to be 'homeless'. **Figure 4.3** illustrates that 63% of the total population of active drug users interviewed reported being currently homeless - as indicated by their accommodation type. This is living in either a hostel, B&B, squat, staying with friends and relatives or sleeping rough. Although not statistically significant, female respondents were more likely than male respondents to report being 'out of home' at the time of the interview. Sixty six percent of female clients reported being currently homeless, compared to 62% of the male clients. There was no difference in the mean age of those clients who reported being homeless (25 years) and those currently housed (24.8 years).

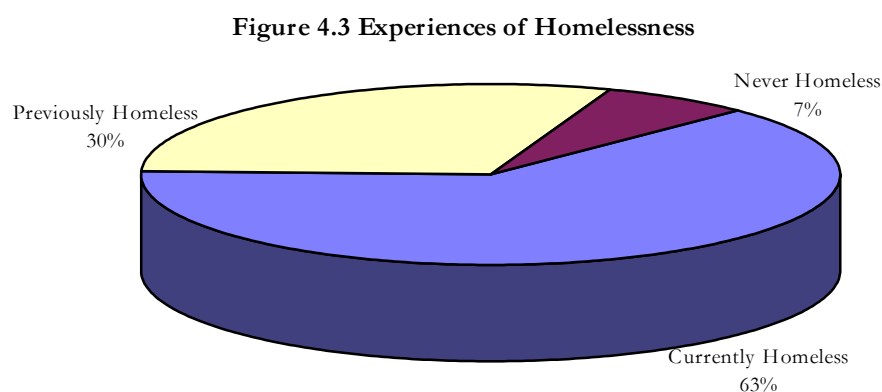


Figure 4.3 also illustrates that a further 30% of clients who completed the screening questionnaire, although not currently homeless, had previous experiences of being homeless. In short, only 7% of the client group interviewed reported that they had never experienced being out of home. **Table 4.1** shows the current sleeping arrangements of the population of drug users interviewed by gender. It

illustrates that 21% of the respondents reported living in their parent’s home. Despite the fact that the female clients were younger than their male counterparts, women were proportionately less likely to report living in their parents home. It also illustrates that only 17% of the female respondents reported living in their family home, compared with 23% of the male respondents. The male clients were also more likely to report staying in a hostel than their female counterparts, while the female respondents were proportionately more likely to report staying in a B&B. Fifteen percent of female clients reported currently staying in a B&B, while only 3% of male clients reported living in this type of emergency accommodation. Table 4.1 illustrates that a significant minority of the population, one fifth, reported currently sleeping rough.

**Table 4.1 Respondents Current Accommodation by Gender**

Accommodation	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Local Authority	6	(8)	10	(6)	7	(14)
Private Rented	9	(12)	7	(4)	8	(16)
Parents Home	23	(30)	17	(10)	21	(40)
Hostel	23	(30)	20	(12)	22	(42)
B&B	3	(4)	15	(9)	7	(13)
Squat	1	(1)	4	(2)	2	(3)
Friends/Relatives	14	(18)	10	(6)	13	(24)
Sleeping Rough	21	(28)	17	(10)	20	(38)
<b>Total</b>	100	131	100	59	100	190

Analysis revealed that there were age differences across accommodation types. **Table 4.2** illustrates that clients who reported that they were privately renting were older than those who reported staying in a hostel, staying with their parents or sleeping rough. The youngest client group were those who reported squatting.

**Table 4.2 Age Breakdown by Accommodation Type**

Accommodation	Age Breakdown					
	<i>N</i>	<i>Mean age</i>	<i>Median age</i>	<i>Mode age</i>	<i>SD</i>	<i>Age Range</i>
Local Authority	14	26.1	24.5	23	4.77	16-34
Private Rented	16	27.6	24.5	23	6.04	19-39
Parents Home	40	23.3	23	23	4.5	16-33
Hostel	42	25.8	25	24	6.05	16-42
B&B	13	26.2	25	25	5.4	19-40
Squat	3	19.3	19	16	3.51	16-23
Friends/Relatives	24	24.5	22	22	5.99	16-43
Sleeping Rough	38	24	22	18	6.28	16-35
<b>Total</b>	190	24.9	24	23	5.84	16-43

All respondents were asked how long they have been in their current living arrangements, whether classified as being housed or homeless. **Table 4.3** illustrates the length of time clients reported living in their current accommodation. Twenty five percent of clients reported living in their current accommodation for a period in excess of five years, while a total of 27% of clients reported being in their accommodation for less than a month. Analysis revealed no significant gender difference in the length of time clients reported being in their current accommodation.

**Table 4.3 Length of Time in Current Accommodation by Gender**

Duration	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
< One week	8	(11)	7	(4)	8	(15)
1-4 Weeks	18	(24)	19	(11)	19	(35)
1-5 Months	18	(23)	22	(13)	19	(36)
6-11 Months	10	(13)	14	(8)	11	(21)
1-4 Years	20	(26)	14	(8)	18	(34)
>5 Years	26	(34)	24	(14)	25	(48)
<b>Total</b>	100	131	100	58	100	189

\*Missing Observations = 1

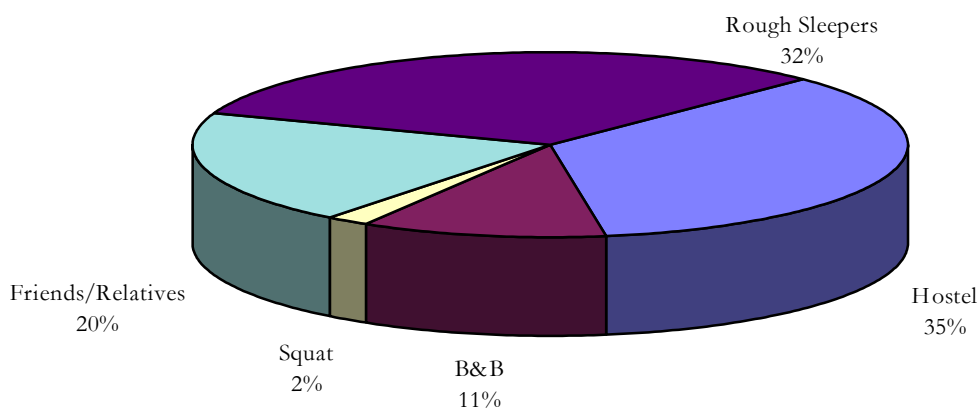
All participants, whether housed in appropriate accommodation or classified as being homeless were asked whether they considered their current accommodation as being temporary or permanent. Analysis revealed that 71% of all clients ( $n=134$ ) reported that their current accommodation was temporary. Of the remaining 56 clients over half were living in their parents home. However, eight clients fell under the classification of 'homelessness' employed in this study; one was living in a hostel, four were staying with friends and/or relatives and three were rough sleepers.

Although not statistically significant there was a gender difference in whether clients stated that their current accommodation was temporary or permanent. Sixty seven percent of the male clients reported that their current accommodation was temporary compared with 78% of the female clients. Not surprisingly, those clients who were considered homeless by type of current accommodation were significantly more likely to report such accommodation as temporary ( $\chi^2=81.5; df=1; p<0.01$ ). Ninety three percent of respondents who were classified as being 'out of home' reported their accommodation as temporary, while only 31% of respondents who were considered housed reported their accommodation as temporary.

### 4.3 HOMELESS DRUG USERS

Concentrating specifically on the cohort who reported being homeless at the time of interview ( $n=120$ ), **Figure 4.4** illustrates their current sleeping arrangements. Almost one third of the homeless clients reported sleeping rough, 46% reported staying in some form of emergency accommodation, 11% in B&B's and 35% in hostels. A further one fifth of the clients reported staying with friends and relatives.

**Figure 4.4 Sleeping Arrangements of Homeless Drug Users**



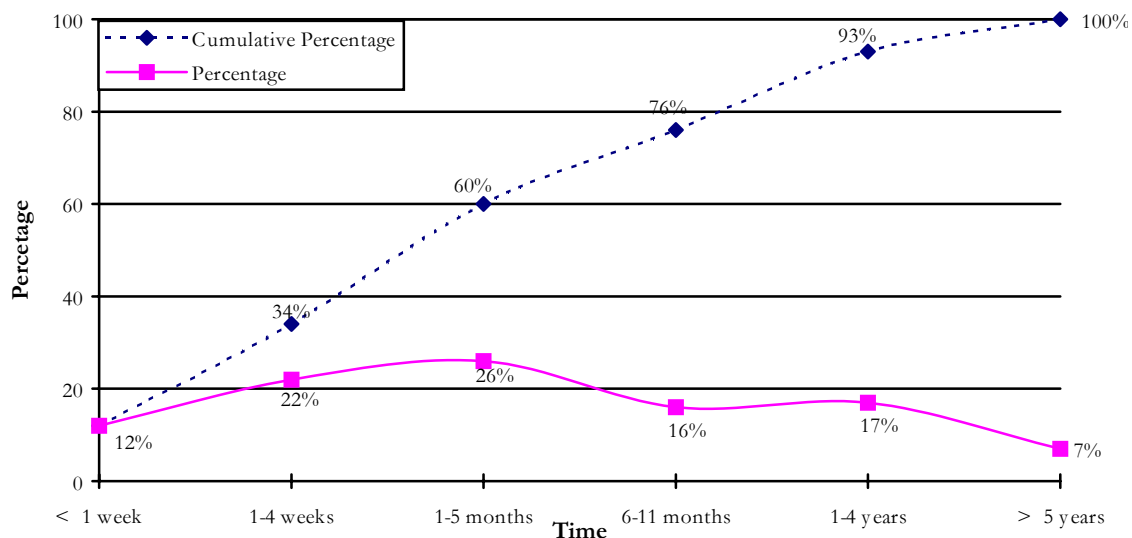
Analysis revealed gender differences across sleeping arrangements among the homeless cohort. **Table 4.4** illustrates these gender differences. It shows that that over a third of this client group reported staying in a hostel. There was a slight gender difference, in that 37% of the male clients reported such current accommodation, compared with 31% of female clients. Analysis revealed that female clients were significantly more likely than their male counterparts to report staying in B&B's ( $\chi^2=9.50;df=1;p<0.01$ ). Overall, levels of sleeping rough were high, as one third of the client group reported sleeping rough at the time of interview. As expected, male clients were more likely to report such sleeping arrangements, however, a significant minority of female clients also reported rough sleeping.

**Table 4.4 Sleeping Arrangements of Homeless by Gender**

Accommodation	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Hostel	37	(30)	31	(12)	35	(42)
B&B	5	(4)	23	(9)	11	(13)
Squat	1	(1)	5	(2)	2	(3)
Friends/relatives	22	(18)	15	(6)	20	(24)
Sleeping Rough	35	(28)	26	(10)	32	(38)
<b>Total</b>	<b>100</b>	<b>(81)</b>	<b>100</b>	<b>(39)</b>	<b>100</b>	<b>(120)</b>

**Figure 4.5** graphically illustrates the length of time homeless respondents reported having been in their current situation. This time period does not necessarily relate to the length of time the clients have been homeless, however it can be seen as an indication of the minimum period of homelessness. Figure 4.5 shows that 12% of the respondents reported being in their current sleeping arrangements for less than one week, and one quarter reported being there for between 1-5 months. Figure 4.5 also illustrates the cumulative time clients have spent out of home. For example it shows that, 34% of the respondents reported being in their current situation for less than one month, while 60% reported being out of home for five months or less.

**Figure 4.5 Length of Time Homeless Respondents Reported Being 'Out of Home'**

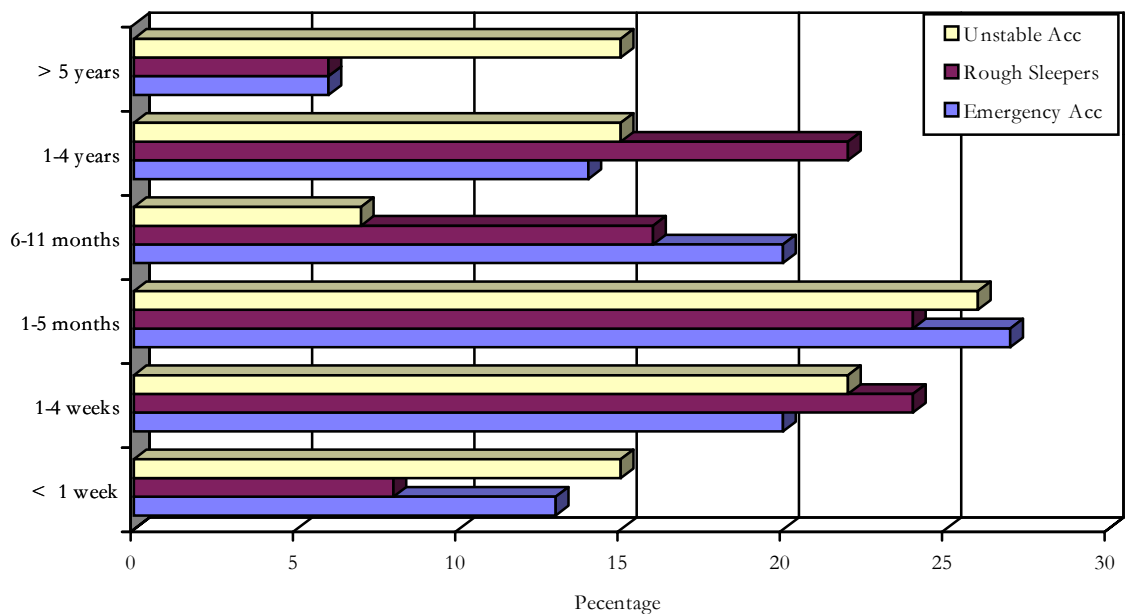


**Figure 4.6** below, illustrates the length of time clients reported being in their current situation by



accommodation type. This figure illustrates that 30% of the homeless clients who were categorised as staying in insecure accommodation (i.e. in a squat or with friends/relatives) were in such accommodation for in excess of one year. While over a quarter of the clients (28%) who reported sleeping rough, did so for over one year. Simultaneously, 37% of those clients who reported staying in unstable accommodation reported being in such accommodation for less than one month. At the same time, 32% of the rough sleepers reported being in that situation for less than one month, and a similar percentage of homeless clients (32%) reported staying in hostels for the same time period.

**Figure 4.6 Length of Time Homeless by Sleeping Arrangements**



#### 4.4 HISTORY OF HOMELESSNESS

All respondents were asked whether they had ever been forced to leave accommodation. **Table 4.5** illustrates that family pressure was the main force which resulted in clients leaving previous accommodation. Male clients were more likely than their female counterparts to report being forced to leave previous accommodation, due to either court order, landlord, vigilantism, tenants/ residence associations or family pressure.

**Table 4.5 Forced to Leave Accommodation by Gender**

Forces	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Court Order	13	(17)	14	(8)	13	(25)
Landlord	12	(16)	9	(5)	11	(21)
Vigilantism	10	(13)	9	(5)	10	(18)
Tenants/ Residence Ass.	8	(11)	15	(9)	10	(20)
Family	42	(55)	37	(22)	41	(77)

\*All percentages adjusted for missing observations

**Table 4.6** highlights respondents previous experience of homeless accommodation. A total of 89% of clients (n=169) reported having stayed in some form of 'homeless accommodation'. There was no significant gender difference in clients reporting such accommodation. Table 4.6 illustrates that a large proportion of clients (64%) reported having previously slept rough. Although not statistically significant, female clients were more likely to report having experienced such accommodation when compared to their male counterparts. Moreover, the reported levels of previously staying in emergency accommodation and sleeping rough were very high among the female respondents.

**Table 4.6 Experience of Homeless Accommodation**

Accommodation	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Emergency	55	(72)	63	(37)	57	(109)
Squat	27	(36)	36	(21)	30	(57)
Sleeping Rough	62	(81)	70	(41)	64	(122)
Friends/Relatives	48	(63)	41	(24)	46	(87)

\*All percentages adjusted for missing observations

Respondents were asked to state what they perceived as being the main reasons for having had to stay in any of the above types of homeless accommodation. **Table 4.7** illustrates by gender clients perceptions on why they have previously had to stay in 'homeless accommodation'. Fifty eight percent of clients reported such experiences were primarily due to drug use, while thirty six percent of clients reported family conflict as a reason. Moreover, the female clients were significantly more likely than their male counterparts to report this ( $\chi^2=6.64$ ;  $df=1$ ;  $p<0.01$ ). Analysis revealed that 49% of the women reported leaving their home due to family conflict, while only 30% of the male clients reported this. The female clients were also significantly more likely than male clients to report having left home due to physical abuse ( $\chi^2=4.45$ ;  $df=1$ ;  $p<0.05$ ).

**Table 4.7 Main Reasons for Staying in Previous Homeless Accommodation**

Reasons	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Family Conflict	30	(39)	49	(29)	36	(68)

Relationship Breakdown	16 (21)	17 (10)	16 (31)
Money Problems	15 (20)	8 (5)	13 (25)
Court Order/Notice to Quit	5 (7)	9 (5)	6 (12)
Told to Leave	19 (25)	20 (12)	20 (37)
Vigilantism	6 (8)	2 (1)	5 (9)
Enter/Leaving Institution	5 (7)	0 (0)	4 (7)
Bad Housing Conditions	4 (5)	5 (3)	4 (8)
Overcrowding/ No Privacy	2 (3)	3 (2)	3 (5)
Drug Use	58 (76)	58 (34)	58 (110)
Physical Abuse	4 (5)	12 (7)	6 (12)
Personal Choice	13 (17)	12 (7)	14 (24)
Other	1 (2)	5 (3)	3 (5)

\*All percentages adjusted for missing observations

Table 4.7 illustrates that 12% of the female clients stated this, compared with 4% of their male counterparts. On the other hand, male clients were more likely to report money problems and vigilantism than female clients. Fifteen percent of male clients reported money problems while 6% of male clients reported vigilantism, compared to only 8% and 2% of female clients reporting these problems respectively.

#### 4.4 DISCUSSION

Although the screening questionnaire was designed primarily to identify those clients who were eligible to participate in the *Survey of Out of Home Drug Users*, it contained valuable information on drug users' experiences of homelessness. One of the most startling figures to emerge from the screening questionnaire was the high levels of homelessness. Sixty three percent of the client group were classified as being homeless by virtue of their current sleeping arrangements - that is, staying in a hostel, B&B, squat, with friends and relatives and/or sleeping rough. In other words, more than one in every two clients were homeless at the time of interview. Equally, the proportion of respondents who [based on the aforementioned accommodation classification] reported having ever experienced homelessness was high. A total of 93% of the cohort were homeless at some point in time.

These high levels of homelessness are no doubt influenced by a number of factors. Firstly, a relatively broad definition of homelessness (by the inclusion of living with friends and relatives) was employed in the study. Research on homelessness often only includes individuals who are currently living in emergency accommodation (i.e. hostels and B&B's) and rough sleepers. Furthermore, time constraints are frequently employed in sampling procedures in other studies. Secondly, the Merchant's Quay Project is in contact with a disproportionate number of homeless drug users. To reiterate a very specific client group presents at the Contact Centre, individuals who are chaotic in both their drug use and other life style factors. It must also be noted that as the Merchant's Quay Project is located in Dublin inner city, close to many homeless services including day facilities and hostels, consequently homeless drug users are more likely to avail of the drug services offered in the Project rather than satellite clinics in the suburbs of Dublin. Finally, seasonal factors are known to influence the utilisation of homeless services. Due to adverse weather conditions homeless persons are more likely to use specialised services during the winter months. Moreover, as will be seen in Chapter Five, homeless drug users are more likely to have nothing to occupy their time and hence their visits tend to be more prolonged. During such time periods homeless drug users are more likely to avail of the hospitality service at the Contact Centre. In short, as this study was conducted in February 1999, it is possible that seasonal factors skewed the results. All the aforementioned, may go towards explaining the high levels of homelessness among presenting clients.

Conversely, it is possible that the levels of homelessness experienced by drug users in this study are indicative of the client group presenting at the Contact Centre. As illustrated in Chapter Two, research in the UK revealed similar levels of homelessness among attendees at low-threshold drug services (Flemen, 1997). To the authors' knowledge there is no comparable Irish research, therefore it is difficult to determine whether the levels of homelessness among the drug users in this study are

realistic. Regardless, the levels of homelessness are cause for concern. The data presented in this chapter also highlighted some other areas of concern which will be summarised below.

*Gender:* The data presented in this chapter support the findings of the international research reviewed in Chapter Two, in that it illustrates that a significant minority of homeless drug users are women. Although not statistically significant, the women in this study were proportionately more likely than their male counterparts to report being currently homeless; 66% of women reported this compared with 62% of the male respondents. The female respondents were also significantly younger than their male counterparts. The mean age for women was 23.2 years, while the male clients were on average 25.7 years. It is clear that homelessness is a problem not only for the male clients presenting at the Contact Centre but increasingly for the female clients. Moreover, by virtue of their younger age, the female clients appear to be at greater risk of experiencing homelessness. Some notable gender differences were also found in accommodation type.

*Accommodation Type:* Of those clients who were homeless (n=120), a significant minority (32%) reported that at the time of interview they were rough sleepers. What is of particular concern is the relatively large number of female clients reporting such sleeping arrangements. An estimated one in four of the female clients were rough sleeping at the time of interview. Moreover, one in every 1.5 women interviewed had previous experience of sleeping rough. A notable characteristic of this group of drug users is that they tend to fall within the lower age ranges (20-24 years).

One in three of the homeless cohort reported currently staying in a hostel. Although not statistically significant the male respondents were significantly more likely than the female clients to report this. This can largely be explained by the limited number of hostel beds in the city available for women. Conversely, women were significantly more likely than their male counterparts to stay B&B accommodation. Twenty three percent of the women reported staying in such accommodation, compared with only 5% of the male clients who were homeless. This is largely due the fact that women are more likely than men to have child care responsibility. A further 22% of the homeless cohort were staying in unsuitable temporary accommodation (i.e. squatting, or staying with friends/relatives). This client group, which consists of almost a quarter of the sample in this study, are frequently omitted from homeless research, due to definitional issues, and consequently their obvious housing needs are easily ignored.

*Length of Time Homeless:* The data collected on clients length of time 'out of home', indicates that approximately one in three of the respondents were homeless for a minimum of one month. Conversely 24% of the homeless clients reported being in their current situation for more than a year, 7% of whom were in inappropriate accommodation for in excess of 5 years. Analysis revealed that there were some notable differences across accommodation type. With regard to those clients who reported sleeping rough over half (56%) reported sleeping in such circumstances for less than 5 months. While, one in three of those who reported staying in unstable accommodation (i.e. with friends/relatives, or squatting) have been doing so for more than one year.

*Causes of Homelessness:* All 'out of home' respondents were asked what they felt were the primary reasons for their current homelessness. Over half the clients (58%) attributed their present living arrangements directly to their drug use, and there was no gender difference in this regard. Twenty percent of the client group reported being 'told to leave' their previous accommodation, and a further 6% specified a court order/notice to quit was the main cause of their homelessness. A worrying feature was that 5% of the client group attributed loss of accommodation to vigilantism. What is of concern is the fact that this figure underestimates the total number of clients who have previously experienced some form of intimidation. A total of 10% of the client group reported having to leave previous accommodation at some point in time, due to vigilantism. A similar percentage reported departure from accommodation due to pressure from tenants and residents associations. This may be as a result of the heightened intolerance for drug related 'anti-social behaviour' on the part of local residents' associations and housing providers.

The data in this chapter indicates that homelessness among chaotic drug users is a major cause for concern. It is also apparent that homeless drug users are not a homogenous group, they include the

highly visible rough sleepers, the often ignored individuals staying in unsuitable temporary accommodation and those availing of emergency accommodation. The population also consists of individuals who have recently being made homeless and people with a long history of living 'out of home'. In order to implement the necessary policy measures to address each specific group, there is a need for increased understanding of homelessness among the population of drug users. To this end, it is essential that policy be informed by both qualitative and quantitative research. The data presented in the next chapter is an attempt to examine homelessness among chaotic drug users.

# CHAPTER FIVE

## SURVEY DATA

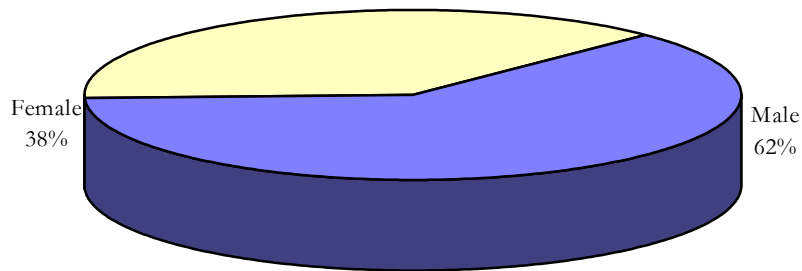
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In this Chapter the data collected from the respondents who completed the *Survey of Out of Home Drug Users* is presented. As outlined in the previous chapter, in order for individuals to be eligible to participate in the survey they had to be active drug users and conform to the definition of homelessness employed in the study. In other words, they had to have been staying in either a hostel, a B+B, a squat, with friends and relatives, or sleeping rough at the time of interview. The screening questionnaire identified 120 active drug users who were eligible to participate in the survey. A total of 59 clients agreed at least in part, to be interviewed that is 49% of those eligible. A total of 53 respondents interviewed completed the questionnaire to an acceptable degree. In this chapter, the demographic characteristics of these 53 homeless drug users are outlined. Thereafter, the current sleeping arrangements of the respondents are examined and a profile of the client groups history of homelessness is presented. A profile of respondents current drug use and their drug using history will also be examined. Where appropriate gender and age differences across variables are presented.

### 5.1 POPULATION CHARACTERISTICS

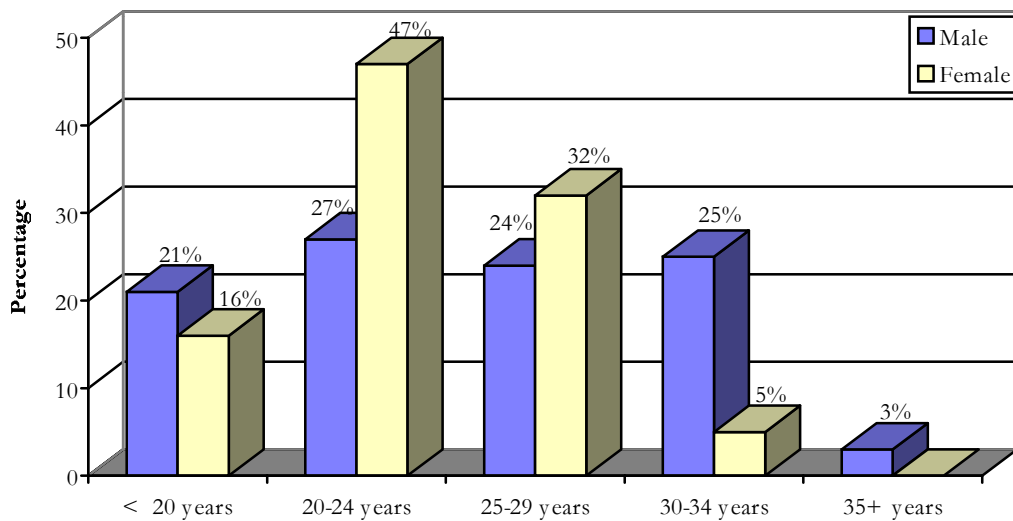
**Figure 5.1** illustrates that over one third of the sample of homeless drug users were female (n=20). This male to female gender ratio of approximately 2:1 supports the findings of international research reviewed in Chapter Two, which indicate that women are increasingly accounting for a larger proportion of the homeless population. As in other research there were notable gender differences across categories of homelessness, this will be discussed when respondents current sleeping arrangements are examined.

**Figure 5.1 Gender**



**Figure 5.2** illustrates the age profile of respondents. The mean age for the sample of homeless drug users was 24.4 years (range 16-35 years). Figure 4.2 illustrates that there was some notable gender differences in the age of respondents. A greater percentage of the female clients were aged between 20-24 years, while male clients were more likely to be over the age of 30 years. Male respondents were also proportionately more likely to be teenagers. Analysis revealed that although not statistically significant, female clients were proportionately younger than their male counterparts. Women were on average 22.8 years of age, while male clients were on average 25.5 years ( $t\text{-test}=1.90$ ;  $df=45.6$ ;  $p<0.06$ ).

**Figure 5.2 Age by Gender**



All respondents were asked about their school leaving age. Seventy one percent of the population left school before the legal school leaving age of 16 years. Eighty percent of the population reported that they had paid employment at some point in time. The remaining 20% reported never having worked. The female respondents were proportionately more likely than their male counterparts to report having had previous employment. Eighty four percent of the women reported this compared with 77% of the male clients. Analysis revealed that there was no notable age difference between the respondents who reported having had previous employment, and those who were never in employment. Clients were also asked about their primary and secondary sources of income. **Table 5.1** illustrates that 32% of the respondents stated that their main source of income was robbing; eight percent of respondents stated prostitution, all of which were female respondents. Only 26% of the respondents stated that unemployment benefit or assistance constituted their primary income. Regarding, secondary sources of income Table 5.1 illustrates that less than half of the population (43%) reported having any secondary source of income.

**Table 5.1 Sources of Income**

Income	Primary		Secondary	
	%	n	%	n
Prostitution	8	(4)	4	(1)
Shoplifting	4	(2)	18	(4)
Lone Parents	6	(3)	9	(2)
Begging	16	(8)	0	(0)
Dole/Assistance	26	(13)	22	(5)
Friends	2	(1)	4	(1)
Robbing	32	(16)	26	(6)
Work	4	(2)	4	(1)
Dealing	2	(1)	4	(1)
Loans	0	(0)	9	(2)
<b>Total</b>	100	50	100	23

Over half the population, 59% reported that they had children. Although not statistically significant, women were proportionately more likely to report having children than their male counterparts. Seventy four percent of female respondents reported having children, compared with 50% of the male respondents. All clients who reported having children were asked about their childcare arrangements. Unfortunately there was a lot of missing data, and based on the valid responses (n=11)

14% of respondents stated that they alone had sole child care responsibilities. Finally, respondents were asked about contact with their families. Over half of the respondents (53%) reported regular family contact (n=49). Analysis revealed that although not statistically significant, male respondents were proportionately more likely than their female counterparts to report regular family contact. Fifty-seven percent of the male clients reported this, compared to 47% of the female respondents. Analysis revealed that there was no age difference between the respondents who reported regular contact with their family, and those who reported no such contact.

Respondents were asked about their experience of imprisonment. Fifty percent of the clients reported that they had served a prison sentence, and a total of 50% also reported having being remanded in custody. Analysis revealed significant gender differences in that male clients were significantly more likely to report having served a prison sentence ( $\chi^2=6.87;df=1;p<0.01$ ), and having being remanded in custody ( $\chi^2=6.87;df=1;p<0.01$ ). Sixty five percent of male respondents reported having served a prison sentence and having been remanded in custody, compared with 26% of the female respondents. Respondents were also asked about their current legal status. **Table 5.2** illustrates that 40% of the respondents reported being on bail at the time of interview, 30% were on probation, and 18% were on temporary release. No client reported being currently on a community service order (categories are not mutually exclusive).

**Table 5.2 Current Legal Status of Homeless Respondents**

Legal Status	Temporary Release %	Suspended Sentence %	Probation %	Bail %
Yes	18	16	30	40
No	82	84	70	60
Total	100	100	100	100
Number	50	50	50	50

## 5.2 CURRENT SLEEPING ARRANGEMENTS

Due to the difficulty in defining ‘homelessness’ and the subjective nature of home and consequently homelessness, all respondents were asked whether they considered themselves to be homeless. The vast majority of clients (83%) reported that they viewed themselves as being ‘homeless’. Of the nine clients who did not perceive themselves as being homeless, one was a man who reported living in a hostel for somewhere between 1-4 years. The remaining eight clients reported living with friends and relatives, for anywhere between 4 weeks to 5 years. As outlined in Chapter Three, all respondents were deemed to be homeless on the basis of their current sleeping arrangements. **Table 5.3** illustrates where clients reported sleeping at the time of interview.

**Table 5.3 Current Sleeping Arrangements by Gender**

Sleeping Arrangements	Male		Female		Total	
	%	n	%	n	%	n
Hostels	36	(12)	15	(3)	28	(15)
B +B	0	(0)	30	(6)	12	(6)
Friends/Relatives	28	(9)	40	(8)	32	(17)
Sleeping Rough	36	(12)	15	(3)	28	(15)
<b>Total</b>	100	(33)	100	(20)	100	(53)



Analysis revealed that there was no significant gender difference in clients reported current sleeping arrangements. However, the data presented in Table 5.3 does suggest that gender influences the sleeping arrangements of respondents. For example male respondents were proportionately more likely than their female counterparts to report staying in hostels. Thirty six percent of the male clients reported currently staying in a hostel compared with only 15% of the female clients. This is largely due to the lack of hostel provision for women. Consequently, women are more likely to report staying in B+B's and with friends/relatives. However, when viewed in terms of 'emergency accommodation' (i.e. hostels and B+B's) women were more likely to report such current sleeping arrangements. On the other hand, male respondents are more likely to be rough sleepers, with over a third of the male respondents reporting this, compared with 15% of female clients.

Analysis revealed that while there was no significant age difference between clients who reported staying in a hostel, B+B or with friends and relatives, rough sleepers were on average younger. The average age of clients who reported sleeping rough was 22.7 years (range 16-34 years) compared with an average of 25.2 years for those in the other categories of accommodation.

**Table 5.4** illustrates the length of time clients reported being in their current sleeping arrangements. Just under one third of the respondents (30%) were in their current circumstances for less than one month, 11% of whom were there for less than one week. Thirty seven percent of the respondents may be considered long-term homeless, in that they have been in their current accommodation for more than one year. **Table 5.5** shows the length of time respondents have been in their current situation by accommodation type. It illustrates that 40% of the respondents who reported staying in a hostel (n=6) were living in such accommodation for more than one year - although not necessarily in the same hostel. On the other hand, 33% of the clients who reported sleeping rough (n=5) had been doing so for less than one month prior to the interview.

**Table 5.4 Length of Time in Current Sleeping Arrangements**

Length of time	Male		Female		Total	
	%	n	%	n	%	n
< one week	12	(4)	10.5	(2)	11	(6)
1-4 weeks	12	(4)	32	(6)	19	(10)
1-5 months	27	(9)	21	(4)	25	(13)
6-11 months	6	(2)	10.5	(2)	8	(4)
1-4 years	31	(10)	21	(4)	27	(14)
> 5 years	12	(4)	5	(1)	10	(5)
<b>Total</b>	100	(33)	100	(19)*	100	(52)

\*Missing Observations = 1

**Table 5.5 Accommodation Type by Time**

Length of Time	Hostel	B+B	Friends/ Relatives	Rough Sleepers	Total
	n	n	n	n	n
< 1 week	1	2	2	1	6
1-4 weeks	2	0	4	4	10
1-5 months	4	2	2	5	13
6-11 months	2	0	1	1	4
1-4 years	4	1	5	4	14
> 5 years	2	0	3	0	5
<b>Total</b>	15	5	17	15	52

Missing Observations = 1

All respondents were asked whether there were any advantages to where they were currently staying. Forty four percent of the respondents stated that there were some advantages. **Figure 5.3** outlines what clients viewed as being the main advantages of their current accommodation. While **Figure 5.4**

presents what clients perceived as being the main disadvantages of their current sleeping arrangements.

### Figure 5.3 Advantage of Current Sleeping Arrangements

*“I can be with my kids all the time”* – 28-year-old male staying with friends

*“The main advantage is that I am not sleeping rough”* – 22-year-old female staying with friends

*“It’s clean and warm and I have good food”* – 23-year-old female staying with friends

*“It’s in out of the rain, and wind, but it is a bit dusty”* – 31-year-old male sleeping rough

*“They look after me well”* – 22-year-old male staying with friends

*“I’m able to beg for money for my habit”* – 34-year-old male sleeping rough

*“Having a bed, a telly and food”* – 17-year-old male staying in a hostel

*“You can cook your own food”* – 25-year-old female staying in a B+B

*“It’s clean and I can wash myself”* – 21-year-old female staying in B+B

*“I’m now off the streets and able to come and go as I please. Because the corporation own the hostel I’m staying in at the moment I am now on the housing list as well”* – 27-year-old male staying in a hostel

*“I don’t have to pay rent”* – 19-year-old male sleeping rough

*“The place is clean, and there are showers and food”* – 27-year-old female staying in a hostel

*“I have a bed, and food”* – 23-year-old male staying in a hostel

*“The only good thing about where I’m staying is that I have a roof over my head”* – 27-year-old male staying in a hostel

**Figure 5.4 Disadvantage of Current Sleeping Arrangements**

*"I have to sneak in and out of the house at all hours of the night so I'm not seen"* – 22-year-old female staying with friends

*"I can be kicked out of here at any time"* – 22-year-old female staying with friends

*"It is miserable, cold and very difficult for me to wash myself"* – 18-year-old male sleeping rough

*"It's small and dirty and the landlord is really ignorant"* – 32-year-old female staying in a B+B

*"It's cold, and lonely especially when I wake up on my own"* – 34-year-old male sleeping rough

*"When you are stoned you are not allowed in"* – 17-year-old male staying in a hostel

*"It's really difficult to get any sleep, and my stuff gets robbed all the time"* – 25-year-old female staying in B+B

*"I have to leave in the morning and can't go back until 6.00pm"* – 21-year-old female staying in a B+B

*"It's not my home"* – 31-year-old male staying friends

*"There is absolutely no privacy and I'm treated like a child and not able to make my own decisions"* – 24-year-old male staying in hostel

*"I don't get much sleep and I'm always getting robbed"* – 34-year-old male sleeping rough

*"I have no privacy and I have to go to bed and get up when I'm told to"* – 35-years-old male staying in a hostel

*"I have no roof over my head, its too noisy, and very dangerous especially when you are on your own"* – 19-year-old male sleeping rough

*"I'm not allowed to stay in the place during the day so I end up having to walk the streets"* – 23-year-old male staying in a hostel

*"I'm always afraid and I never feel safe, whether I'm sleeping on the streets or in a hostel or a B+B"* – 21-year-old female sleeping rough

*"Everybody is using drugs here, that makes it impossible to try and stay off drugs"* – 20-year-old female staying in a hostel

*"The worst thing is having nobody to go home to"* – 22-year-old male staying in a hostel

### 5.3 CURRENT USE OF HOMELESS SERVICES

All respondents were asked whether they were currently in contact with homeless drug services. A total of 83% of the respondents reported that they were attending at least one centre that explicitly provided services for the homeless. Respondents were then asked to complete a checklist of homeless services, stating whether they used these services or not. **Table 5.6** illustrates the percentage of male and female clients who reported contact with the ten identified services for the homeless in the Greater Dublin Area. Many of the respondents reported contact with services that are specifically geared towards seeking accommodation. For example 71% of the clients were in contact with Focus Ireland, 43% reported having been in contact with the Dublin Corporation, while only 4% reported being in contact with Threshold. Table 5.6 also illustrates that over half the respondents reported having been in contact with Failtiu/Tea Rooms. This level of contact was expected as the interviews were conducted in the same building as Failtiu. Moreover, referrals in and between the Merchant's Quay Project and Failtiu are frequent.

**Table 5.6 Use of Homeless Services by Gender**

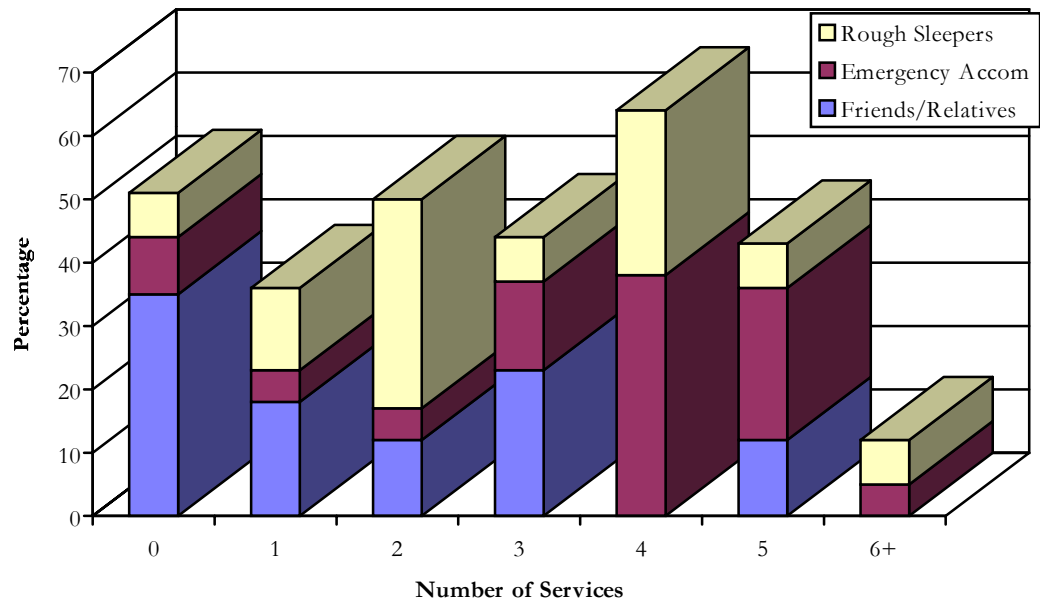
Service	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Focus Ireland	63	(20)	84	(16)	71	(36)
Threshold	6	(2)	0	(0)	4	(2)
Failtiu/Tea Rooms	47	(15)	63	(12)	53	(27)
Capuchin Day Centre	6	(2)	11	(2)	8	(4)
Crosscare Food Centre	13	(4)	0	(0)	8	(4)
Tallaght Homeless Adv.Cent.	3	(1)	0	(0)	2	(1)
Simon Soup Run	50	(16)	26	(5)	41	(21)
Charles St. Health Centre	56	(18)	53	(10)	55	(28)
Dublin Corporation	31	(10)	63	(12)	43	(22)
Ushers Island	3	(1)	0	(0)	2	(1)

\* All percentages adjusted for missing observations

Table 5.6 illustrates some notable gender differences in reported contact with homeless services. None of the female clients reported being in contact with Threshold, Crosscare or Ushers Island. However, women were proportionately more likely to report contact with Failtiu/Tearooms and Focus Ireland. Although not statistically significant ( $\chi^2=2.76$ ;  $df=1$ ;  $p<0.09$ ) there were substantial gender differences in reported contact with the Simon Soup Run, in that 50% of the male respondents reported such contact, compared with only a quarter of the female clients. However, the female respondents were significantly more likely to report contact with Dublin Corporation ( $\chi^2=4.94$ ;  $df=1$ ;  $p<0.05$ ).

Eighty three percent of the sample of homeless drug users accounted for all the contacts with services highlighted above in Table 5.6. In other words, 17% of the sample, or 9 individuals reported no contact with any homeless service. Analysis of data revealed that there were differences across accommodation type in reported contact with homeless services. **Figure 5.5** illustrates that respondents who reported living with friends and relatives were proportionately more likely than rough sleepers or those staying in emergency accommodation (i.e. hostels and/or B+B's) to report having no contact with homeless services. Thirty five percent of those who reported living with friends and relatives were not in contact with homeless services. Conversely, thirty eight percent of the respondents living in emergency accommodation, and 26% of rough sleepers reported being in contact with four of the above homeless services.

**Figure 5.5 Contact with Services by Accommodation Type**



Furthermore, only 17% of the respondents who reported living with friends and relatives (n=3) reported using the Simon Soup Run. Conversely 42% of those living in emergency accommodation (n=9) and 60% of the rough sleepers (n=9) reported using this service. Equally individuals living with friends and relatives were proportionately less likely to report contact with Focus Ireland. Only 47% of respondents in this category of homelessness reported such contact compared with 86% of those in emergency accommodation and 67% of rough sleepers. The majority of those living in emergency accommodation (76%) reported being in contact with Charles Street. Although rough sleepers (47%) were proportionately more likely than respondents staying with friends and relatives (29%) to report such contact, levels of contact among this client group were still relatively low.

## 5.4 HISTORY OF HOMELESSNESS

In order to gain some insight into the history of respondent's homelessness, all clients were asked where was the last place they thought of as home. **Table 5.7** illustrates that over half the respondents (63%) regarded their parent's residence as their last home. This may largely be due to the fact that the client group was relatively young, with a mean age of 24.4 years. However, male clients while older than their female counterparts were proportionately more likely to report their parents residence as home. Seventy percent of the male clients reported this compared with 50% of the female clients. An additional 7% of the respondents classified 'other' as their last home, two of these respondents specified a hostel (one of these respondents did not consider themselves homeless) and a further two stated that prison was the last place they thought of as home.

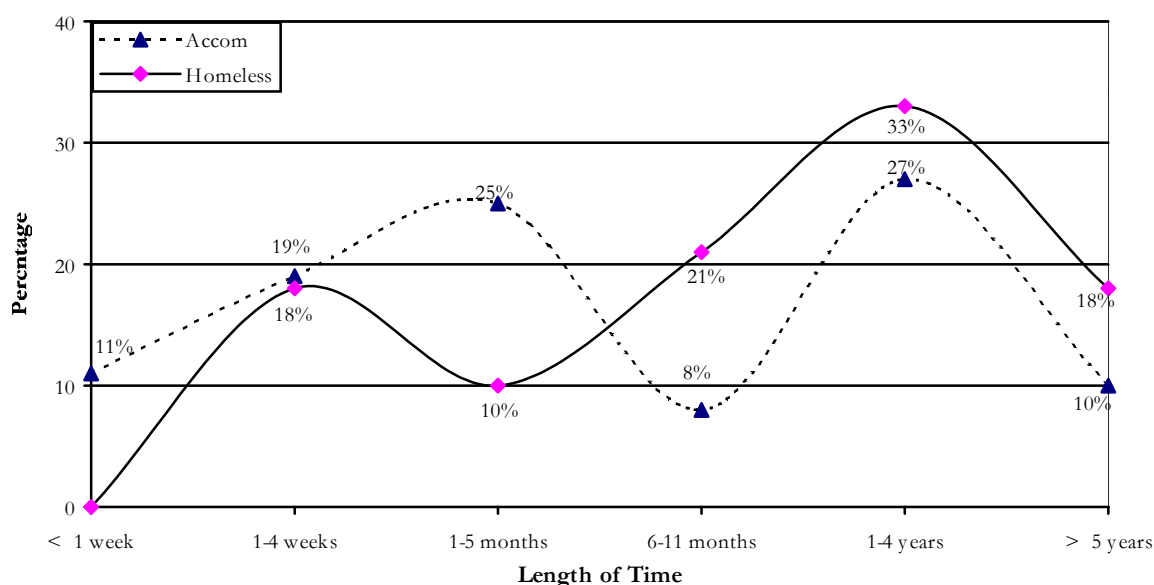
**Table 5.7 Last 'Home' by Gender**

Last Home	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Never had a home	0	(0)	6	(1)	2	(1)
House owned	3	(1)	0	(0)	2	(1)
Rented Accom.	9	(3)	28	(5)	16	(8)
Parents home	70	(23)	50	(9)	63	(32)
Friends/Relatives	9	(3)	11	(2)	10	(5)
Other	9	(3)	5	(1)	7	(4)
<b>Total</b>	100	33	100	18	100	(51)

Missing Observation = 2

All respondents were asked how long they have been 'out of home'. **Figure 5.6** graphically illustrates this data in conjunction with the length of time clients reported being in their current accommodation. It is immediately apparent that disparities exist, and that the length of time in current accommodation is not an accurate depiction of length of time 'out of home'.

**Figure 5.6 Length of Time Out of Home and in Current Accommodation**

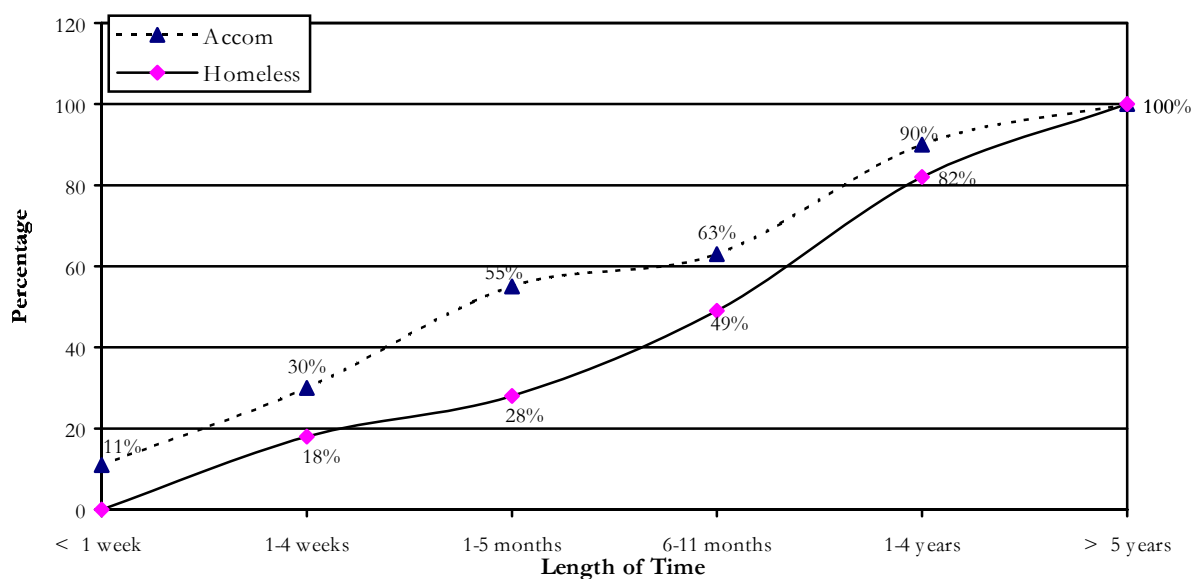


For example, Figure 5.6 shows that no respondent has been out of home for less than one week, while 11% of the population reported being in their current accommodation for less than one week. A further 8% of clients reported being in their current accommodation for between 6 to 11 months, while 21% of clients reported being homeless for this time period. At the same time, 18% of the respondents reported being out of home for in excess of five years, while only 10% of the population reported being in their current accommodation for this length of time.

**Figure 5.7** further highlights the disparity between length of time in current accommodation and length of time out of home. This figure illustrates the cumulative length of time respondents reported being out of home and in their current accommodation. For example, 18% of respondents reported being homeless for less than four weeks, while 30% of the respondents reported staying in their current accommodation for this time period. The suggestion is that the difference between the two -

which is 12% of respondents - were individuals who were homeless for more than 4 weeks, but in their current accommodation for less than four weeks. In short, it would appear that homeless individuals move not only in and out of homelessness, but also across categories of homelessness, for example from hostels to rough sleeping.

**Figure 5.7 Cumulative Time Out of Home and in Current Accommodation**



Clients were asked what they considered to be the main reasons for them leaving 'home'. Recognising that in many incidences there may be no one simple reason, respondents were permitted to give up to three primary reasons. **Table 5.8** illustrates that 64% of the respondents in some way attributed leaving 'home' to their drug use. There was no reported gender difference in this regard. A further 38% of respondents stated that family conflict was one of the primary reasons. However, Table 5.8 illustrates a gender difference in this regard, in that female clients were more likely to state family conflict as a reason for being out of home; 47% of women reported this, compared with 33% of male clients. Sixteen percent of the population reported that they were forced out of their accommodation in some way, either through a court order/notice to quit, by their landlord, or due to vigilantism. Regarding the latter, only male respondents reported that they had to leave their home as a result of



such activity.

**Table 5.8 Reasons for Leaving ‘Home’**

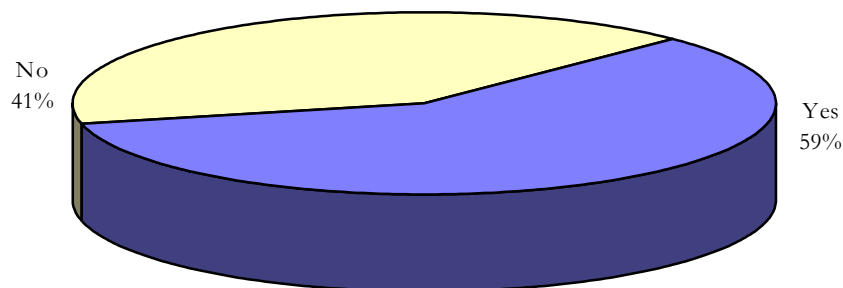
Reasons	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Family Conflict	33	(11)	47	(9)	38	(20)
Relationship Breakdown	21	(7)	5	(1)	15	(8)
Money Problems	12	(4)	10	(2)	11	(6)
CourtOrder/Notice to Quit	3	(1)	10	(2)	6	(3)
Told to go – Landlord	6	(2)	5	(1)	6	(3)
Vigilantism	6	(2)	0	(0)	4	(2)
Enter/Leave Institution	3	(1)	5	(1)	4	(2)
Bad Housing Conditions	3	(1)	0	(0)	2	(1)
Overcrowding/no Privacy	6	(2)	16	(3)	10	(5)
Drug Use	64	(21)	63	(12)	64	(33)
Physical/Sexual Abuse	6	(2)	21	(4)	11	(6)
Personal Choice	12	(4)	16	(3)	14	(7)
Other	9	(3)	5	(1)	8	(4)

\*All percentages adjusted for missing values

The data presented in Table 5.8 is not an attempt to explain homelessness among injecting drug users. In many cases the reasons presented by clients for leaving their home, are complex and interconnected. For example, one respondent stated that the main reasons for leaving his parents home were due to his drug use, family conflict and relationship breakdown. As this individual was an injecting drug user for the previous six years, it is reasonable to assume that his drug use had an impact on the family and the relationships therein. At the same time it is conceivable that family conflict may be a casual factor in the individuals drug use. The data presented in Table 5.8 while not highlighting the causal factors of homelessness among drug users, nevertheless provides a valuable insight into drug users subjective perceptions of the reasons for their ‘own’ homelessness.

All respondents were asked whether their current experience of being homeless was their first. **Figure 5.8** illustrates that over half of the sample group (59%) reported that this current episode of homelessness was not their first experience of being out of home. Analysis revealed that although not statistically significant, there was a gender difference in previous experience of homelessness. Female clients were proportionately more likely than their male counterparts to report having had prior experiences of homelessness. Sixty three percent of the women in the sample reported this compared with 56% of the male respondents. An age difference was also noted, in that the respondents who reported their current experience of homelessness as being their first were on average 25.3 years of age, while respondents who had previous experience of homelessness were on average 23.6 years of age.

**Figure 5.8 Previous Experience of Homelessness**

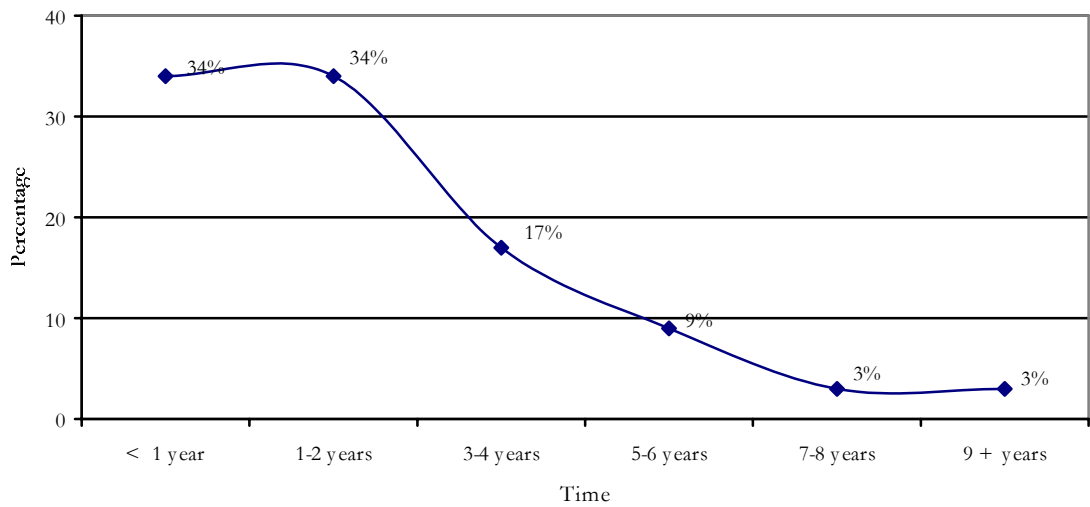


The mean age of first homelessness for the sample was 19.2 years (range 6 to 33 years). Analysis revealed that women were first homeless at a slightly younger age than male respondents. The female respondents were on average 18.4 years of age when first homeless, while the male respondents were on average 19.6 years of age. The clients (59%) who reported that their current homeless episode was

not their first (n=30) were asked the number of homeless episodes they have experienced. Data was only available on 22 of the 30 respondents who had prior experience of homelessness. Nineteen percent of the respondents reported three episodes of homelessness (n=4) a further 10% reported four episodes of homelessness and 14% reported five episodes. Thirty three percent of the respondents reported that they have been homeless so many times that they have lost count (n=7). The remaining 24% of clients reported in excess of 5 incidences of homelessness.

All respondents were asked the longest period of homelessness they have experienced. The mean length of time out of home for the sample is 2.26 years (range 10 weeks to 12 years). Analysis revealed that although not statistically significant, female clients on average experienced longer periods of homelessness than their male counterparts. Women reported an average of 2.5 years of homelessness, their male counterparts reported 2 years of homelessness. **Figure 5.9** graphically illustrates the respondents longest period out of home. Thirty four percent of the respondents reported that their longest period out of home was less than one year. A further 34% reported that their longest period out of home was between 1-2 years. Three percent of the sample reported that their longest time out of home was in excess of nine years.

Figure 5.9 Longest Period Out of Home



The respondents were also asked about the number of times they have stayed in hostels, B+B's, with friends, and slept rough. The responses to this question were unsatisfactory and often incomplete. This was partially due to the fact that there was some misunderstanding around the question wording, in that, some clients responded by stating the number of times they stayed in such accommodation (as required) while others stated the length of time they have spent in such accommodation. Furthermore, some clients were simply unable to recall the information to answer the question accurately.

For the data available what is known is that 31% of the respondents reported that they never stayed in a hostel. A further 15% of the clients reported that they have stayed in hostels at some point in time, but they did not specify the number of times, and 9% of the sample reported that they had stayed in hostels so many times they had lost count. As stated previously, some respondents reported the length of time they have spent in the particular accommodation type. The average length of time clients reported staying in hostels was 18 weeks (range 1 night to 5 years). Regarding the other form of emergency accommodation, B+B's, 47% of the clients reported that they have never stayed in such accommodation. Eight percent of the respondents were known to have stayed at some time in a B+B but they did not state the number of occasions. Seventeen percent of the sample reported that they stayed in a B+B once, 6% reported staying on two occasions, and the remaining 18% stayed between 3 and 25 times in a B+B.

Forty seven percent of the clients reported that they never stayed with friends or relatives. Six percent of the clients reported having stayed with friends and/or relatives, however they did not specify how many times, and a further 15% reported staying in such accommodation more times than they can count. The remaining 32% of respondents reported staying in such accommodation anywhere between 1 to 31 weeks. Finally 32% of the clients reported having never slept rough. Fourteen percent were known to have slept rough at least once. Over a quarter of the clients reported that they had slept on the streets more times than they can count. A further fourteen-percent stated that they have slept rough once, and the remaining 12% of respondents slept rough on at least three separate occasions. The longest period of sleeping rough reported by a client was 32 consecutive weeks.

Regarding clients history of homelessness, all respondents were asked if they had ever been forced out of their accommodation due to vigilantism, pressure from their families, landlord or other tenants. **Table 5.9** illustrates that 46% of the respondents reported that they were forced out of their accommodation due to pressure from their family. The male respondents were proportionately more likely than the female respondents to report this. Twelve percent of the sample reported that they had to leave their accommodation due to pressure from other tenants or residents associations. Although it was not statistically significant, female clients were proportionately more likely to report this than

their male counterparts. According to Table 5.9 only 10% of the sample were forced out of their homes due to vigilantism.

**Table 5.9 Forced Out of Accommodation**

Left Accommodation due to	Male		Female		Total	
	%	n	%	N	%	n
Court Order/Notice to Quit	6	(2)	22	(4)	12	(6)
Told to go by Landlord	13	(4)	5	(1)	10	(5)
Vigilantism	13	(4)	5	(1)	10	(5)
Pressure–Tenants/Res. Association	10	(3)	16	(3)	12	(6)
Pressure – Family	55	(17)	32	(6)	46	(23)

Finally, the respondents were asked about their experience of police harassment since being homeless, and whether they had committed drug related and non-drug related crimes since being out of home. **Table 5.10** illustrates that 44% of the respondents reported that they have been the victim of a crime since they became homeless. This supports the information provided in Figure 5.4 where a number of clients stated that the main disadvantage of where they are currently staying is the fact that they are vulnerable to crime, robbery in particular. Thirty six percent of the clients reported having committed a drug-related offense, and 26% committed a non-drug-related crime since being homeless. The male respondents were significantly more likely than the female clients to report that they had committed a non-drug related crime ( $\chi^2=6.84;df=1;p<0.01$ ). Finally, levels of reported police harassment were high, 68% of the respondents reported that they have been harassed by the police since being out of home.

**Table 5.10 Experiences While Out of Home**

Since being homeless	Male		Female		Total	
	%	n	%	n	%	n
Victim of a Crime	45	(14)	42	(8)	44	(22)
Committed Drug Related Crime	45	(14)	21	(4)	36	(18)
Committed Non-Drug Related Crime	39	(12)	5	(1)	26	(13)
Harassed by the Police	74	(23)	58	(11)	68	(34)

## 5.5 PATHWAYS OUT OF HOMELESSNESS

In order to get respondents to think of possible pathways out of their homelessness, they were first asked what they regarded as being their ideal accommodation. In other words, if all things were possible, where would they most like to live. Although over half the population (63%) considered their parents home as the last place they thought of as home, only 8% of the respondents reported that this is their ideal accommodation. The majority of respondents (82%) reported that ideally they would like their own accommodation, which predominantly took the form of a private rented house/apartment. The remaining respondents reported specific requirements such as “a clean and bigger place”, “a drug free environment” and “a place of my own”.

Respondents were then asked to identify which of the factors presented in Table 5.11 they regarded as playing a key role in preventing them from accessing such accommodation. **Table 5.11** illustrates that over half the respondents (57%) identified their drug use as a barrier to getting their ideal accommodation. Women were slightly more likely to report this than the male clients. Thirty seven percent of the population identified lack of finances, or money problems as a barrier. Although not statistically significant, the male respondents were proportionately more likely to report money problems as a factor in preventing them from obtaining their ideal accommodation ( $\chi^2=2.68; df=1; p<0.1$ ). Conversely, female respondents were significantly more likely to report lack of help as a factor in preventing them from getting accommodation ( $\chi^2=8.6; df=1;p<0.01$ ). Table 5.11 illustrates that 44% of the female respondents reported this, compared with 9% of the male clients.

**Table 5.11 Reported Barriers to Obtaining Ideal Accommodation**

Reasons	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Lack of Housing	27	(9)	11	(2)	22	(11)
Money Problems	45	(15)	22	(4)	37	(19)
Drug Use	52	(17)	67	(12)	57	(29)
Lack of help getting Accom	9	(3)	44	(8)	22	(11)
Not tried to get Accom	3	(1)	0	(0)	2	(1)
Not welcome in such Accom	12	(4)	6	(1)	10	(5)
Other	6	(2)	11	(2)	8	(4)

\*All percentages adjusted for missing observations

Finally it is worth noting that only 22% of the population viewed lack of housing as a factor in preventing them from acquiring their ideal accommodation. In view of the current housing situation in Dublin, and the fact that in the majority of cases respondents ideal accommodation were private rented houses/flats, the suggestion is that it plays a more important role than clients perceive it to. The experience of insecure housing in the future may have immense implications for relapse prevention.

Respondents were then asked to identify the kind of help they felt they needed to enable them to get their ideal accommodation. Ninety eight percent of the population reported that they needed some kind of help in getting their ideal accommodation. **Table 5.12** illustrates that 71% of the clients reported that they felt drug treatment would help them in getting their ideal accommodation. Male clients were proportionately more likely than their female counterparts to report this. Just under half the respondents, 47% reported that they needed financial help. A similar proportion of respondents reported needing advice and information. Although not statistically significant, female clients were more likely to report this than male respondents ( $\chi^2=2.88;df=1;p<0.08$ ).

**Table 5.12 Help Needed in Obtaining Ideal Accommodation**

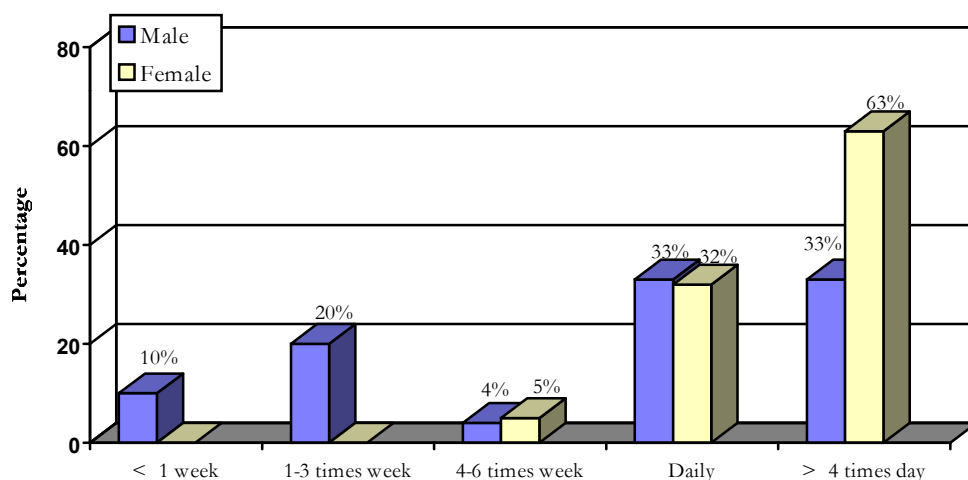
Help Required	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Advice and Information	36	(12)	61	(11)	45	(23)
Financial Help	55	(18)	33	(6)	47	(24)
Drug Treatment	73	(24)	67	(12)	71	(36)
Other Help	6	(2)	6	(1)	6	(3)

## 5.6 DRUG USE

All respondents were asked in detail about their drug use, in particular their injecting risk behaviour. The mean age of first drug use for the sample group was 15.8 years (range 8-28 years). Over half the population, 56% had started using illicit drugs before the age of 15 years, only 11% were over the age of twenty when they first started using drugs. Although not statistically significant, the male respondents started using drugs at a younger age than their female counterparts. Male clients had a mean age of 15 years for first drug use, while the female clients had a mean age of 16 years.

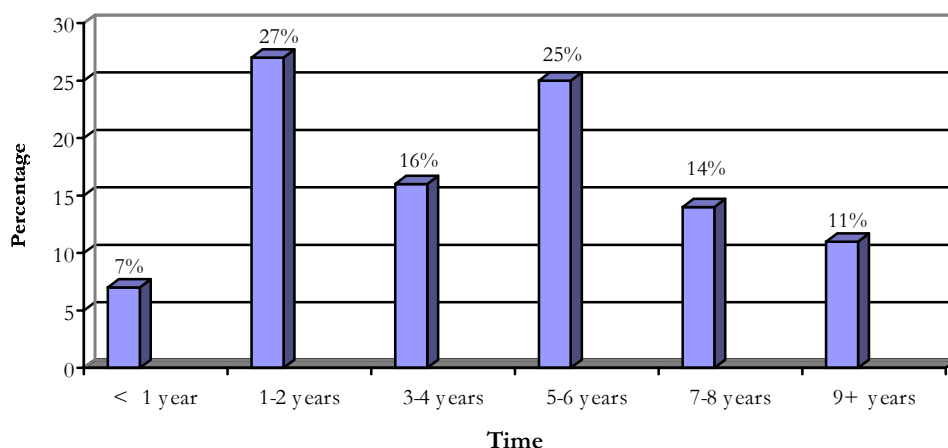
The vast majority of clients reported using heroin as their primary drug. Only one respondent stated otherwise, and reported using (prescribed) physeptone as their primary drug. Equally, the majority of respondents reported injecting their primary drug, with only two respondents stating that they smoked heroin. Respondents were asked how often they used their primary drug in the four weeks prior to interview. **Figure 5.10** illustrates that the female respondents were more likely to use their primary drug four or more times a day. Conversely male respondents were more likely to report using their primary drug less than once a week.

**Figure 5.10 Frequency of Drug Use by Gender**



**Figure 5.11** graphically illustrates the length of respondents injecting careers. Only 7% of the respondents were injecting drug users for less than one year. Over a quarter of the sample reported injecting drugs for 1-2 years and 11% were injecting drug users for 9 years and more. The average length of respondents injecting career was 5.25 years (range 1 week to 19 years). Analysis revealed that the male respondents had significantly longer injecting careers than their female counterparts ( $t$ -test=2.37;df=42;p<0.05). Male clients were injecting for on average 6.18 years, while the female respondents reported injecting for on average 3.45 years.

**Figure 5.11 Length of Time Injecting**



All respondents were asked whether they were using any secondary drugs. Sixty one percent of the clients reported poly-drug use (n=31), fifty two percent of whom reported injecting their secondary drug. Analysis revealed that male respondents were significantly more likely to report being poly-drug users than their female counterparts ( $\chi^2=4.43$ ; df=1;p<0.05). Seventy two percent of the male respondents reported being poly-drug users compared with 42% of the female clients. One quarter of the respondents who reported poly-drug use stated that their secondary drug was hash, 29% reported using physeptone, 23% reported using benzodiazepines, and 23% reported used cocaine.

Participants were asked in some detail about their injecting behaviour. All respondents were asked whether they usually injected in public or private. **Table 5.13** illustrates that over half the respondents stated that they are usually in a public place, be it a park, public toilets or anywhere else exposed when

they inject. Analysis revealed that the male respondents were significantly more likely to report injecting in public places than their female counterparts ( $\chi^2=6.01;df=1;p<0.05$ ). Seventy nine percent of the male clients reported that they usually inject in some public place, compared with 44% of the female respondents.

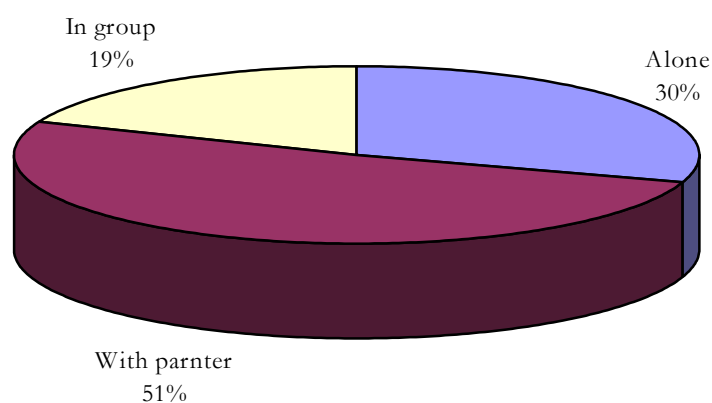
**Table 5.13 Injecting Behaviour**

Place of Injecting	Male		Female		Total	
	%	n	%	n	%	n
Place of Residence	21	(6)	28	(5)	23	(11)
Home of Friends/Relatives	0	(0)	28	(5)	11	(5)
Park/Public place	65	(19)	33	(6)	53	(25)
Pub /Public toilets	14	(4)	11	(2)	13	(6)

Further analysis revealed that the respondent's current sleeping arrangements was related to whether clients reported injecting in public places. Not surprisingly, respondents who were rough sleepers were significantly more likely to report injecting in public places than those who reported staying with friends and relatives ( $\chi^2=11.23;df=3;p<0.05$ ). Ninety two percent of rough sleepers reported that they inject in public places, compared with 37% of those staying with friends. Similarly, a very high percentage of individuals staying in hostels (79%) reported that they injected in public places.

All respondents were asked with whom they usually injected. **Figure 5.12** illustrates over half the respondents reported that they inject with their partner, 30% reported that normally they inject alone, and 19% reported they are usually in a group when they inject. Analysis revealed that although not statistically significant, female respondents were proportionately more likely than their male counterparts to report injecting with their partner. Twenty two percent of the female clients reported this, compared with 17% of the male respondents. There was also no significant difference in injecting habits across categories of accommodation. However, over half the respondents who reported sleeping rough (54%) and staying in hostels (57%) reported that they usually injected in a group setting.

**Figure 5.12 Injecting Habits**



Regarding injecting risk behaviour, all respondents were asked about the sharing of injecting equipment in the four weeks prior to interview. **Table 5.14** illustrates that almost half the sample reported the recent sharing of injecting paraphernalia, that is spoons and filters. Respondents were more likely to report borrowing used injecting equipment from others rather than lending others their used equipment. Although there was no significant gender difference in the levels of such sharing, male respondents were proportionately more likely to report lending others their used injecting equipment. Further analysis revealed that there was no significant difference in reported injecting risk behaviour across categories of accommodation.

**Table 5.14 Injecting Risk Behaviour**

Recent Sharing Behaviour	Male		Female		Total	
	%	n	%	n	%	n
Shared IV paraphernalia	53	(16)	42	(8)	49	(24)
Lent Used IV equipment	23	(7)	5	(1)	16	(8)
Borrowed used IV equipment	23	(7)	26	(5)	24	(12)

\*Missing Observations = 4

All respondents were asked whether being out of home had changed their injecting behaviour. Over half the respondents reported that their behaviour had changed. **Figure 5.13** presents the clients responses.

**Figure 5.13 Changes in Injecting Behaviour**

*“I’m using more and so I have to work more {as a prostitute} for money”* – 21-year-old female sleeping rough

*“I’m less careful about my injecting now”* – 22-year-old male sleeping rough

*“I’ve nowhere safe or private to inject”* – 26-year-old female staying in a hostel

*“I’m injecting a lot more, before I mainly smoked”* – 19-year-old male sleeping rough

*“Now I’ll have a fix anywhere”* – 22-year-old male staying with friends

*“I’m using less now, for some reason or other”* – 28-year-old male staying with friends

*“Ever since I moved out of home I have been less health conscious, and I’m now injecting into my groin”* – 32-year-old male staying in a hostel

*“It’s made me snap out of it, and I’m now trying to get on a methadone detox programme”* - 16- year-old female staying in a hostel

*“It’s really hard to inject safely now”* – 27-year-old male staying in a hostel

*“I have been using a lot more since I moved in with my friends, but that is because there are other drug injectors in the house”* – 22-year-old male staying with friends

*“It’s made me more depressed, and when I’m depressed I use more”* – 25-year-old female staying in a hostel

*“I’ve got really careless about safe injecting, because I don’t have fresh water and a safe place to inject”* - 35-year-old male staying in a hostel

*“I’m using a lot more now because on the streets I can, at home I couldn’t really use”* – 34-year-old male sleeping rough

*“I’m using a lot more because I’m bored and have nothing to do all day and night”* – 18-year- old male sleeping rough

*“I’m using more to try and forget about being homeless”* – 21-year-old female staying in a B+B



Respondents were also asked specifically about their drug use, and whether as a result of being homeless their drug use had changed in any way. Sixty six percent of the sample group reported that their drug use had changed since being ‘out of home’. **Table 5.15** illustrates that 56% of the respondents reported that as a result of being homeless they were using more drugs. For example as one client said;

*“I’m just so bored all the time, I have nothing to do all day so I use a lot more”*

- 19-year-old male sleeping rough

Another respondent attributed his increase in drug use since being homeless to having more money. The client stated;

*“I have more money now from begging so I can afford to use more often”*

34-year-old male sleeping rough

Seven percent of the respondents stated that being made homeless, has made them want to stop using drugs, and a further 4% reported using less drugs since being out of home. Nine percent of the clients stated that their drug use has become more erratic and out of control since being out of home. For example, one client stated;

*“I used to only use heroin, and then I started using a lot of cocaine, and now, I have started to inject roche. It’s all just got out of control”* -16-year-old female sleeping rough

**Table 5.15 Changes in Drug Using Behaviour**

Changes	Number	Percentage
Using More	26	56
More erratic/unpredictable use	4	9
More motivated to stop	3	7
Using less	2	4
No change	11	24
<b>Total</b>	46	100

\* Missing Observations = 7

All respondents were also asked about their alcohol consumption. **Table 5.16** illustrates that over a quarter of the sample (27%) reported never drinking alcohol. Although not statistically significant, women were proportionately more likely than their male counterparts to report this. On the other hand, 8% of the sample reported daily alcohol consumption.

**Table 5.16 Frequency of Use of Alcohol**

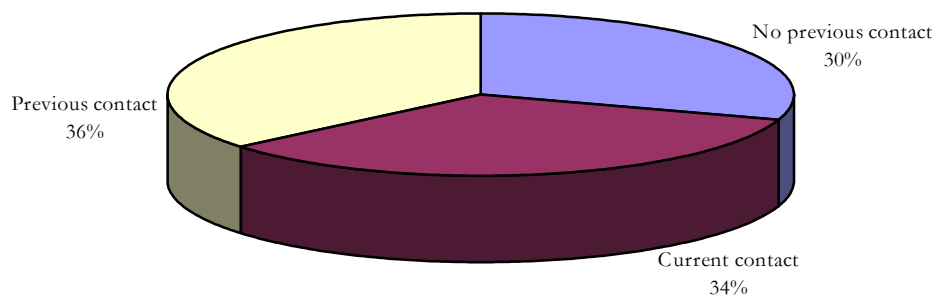
Alcohol Use	Male		Female		Total	
	%	n	%	n	%	n
Almost Daily	10	(3)	6	(1)	8	(4)
3-4 time a week	4	(1)	10	(2)	6	(3)
1-2 time a week	33	(10)	6	(1)	23	(11)
Rarely	33	(10)	39	(7)	36	(17)
Never	20	(6)	39	(7)	27	(18)

\*Missing Observations = 5

## 5.7 USE OF DRUG TREATMENT SERVICES

As outlined in Chapter Three all respondents presented at the Merchant's Quay Project, Contact Centre. Consequently, the respondents were not necessarily representative of homeless drug users, as they were out of home drug users who were in contact with at least one treatment service. Moreover, **Figure 5.14** illustrates that one third of the clients (34%) reported that they are in current contact with another drug treatment service. A further 30% of the respondents reported no contact with any other drug treatment service, apart from the Merchant's Quay Project.

**Figure 5.14 Contact with Drug Treatment Services**



Analysis revealed that although not statistically significant, there was a gender difference in clients reported current contact with drug treatment services. Female respondents were proportionately more likely than their male counterparts to report such contact. Forty two percent of the women reported attending other drug services, compared with 29% of the male respondents. There was no significant age difference between respondents who reported current treatment contact and those not in contact with treatment services.

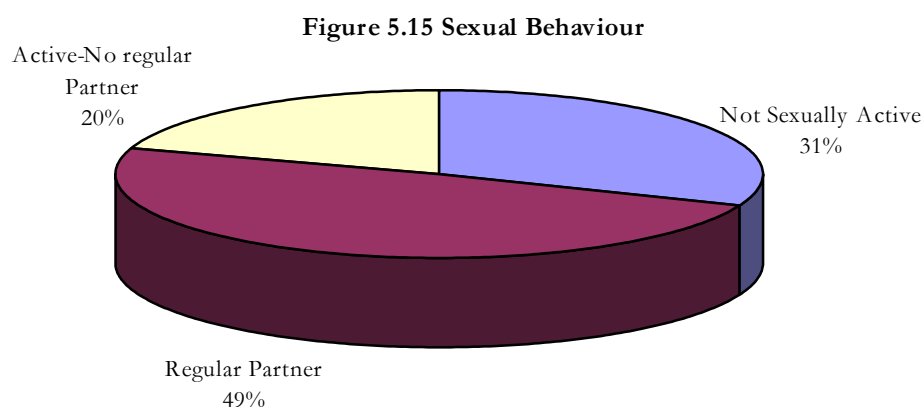
**Table 5.17** illustrates the extent to which clients utilised the services in the Merchant's Quay Project. Analysis revealed that there were gender differences in reported contact with services within the project. For example, male clients were significantly more likely than their female counterparts to report contact with the Health Promotion Unit (including the needle exchange), ( $\chi^2=4.4$ ;  $df=1$ ;  $p<0.05$ ). Conversely, female respondents were significantly more likely than male respondents to report availing of the contact work within the project ( $\chi^2=3.7$ ;  $df=1$ ;  $p<0.05$ ) and the massage service ( $\chi^2=5.51$ ;  $df=1$ ;  $p<0.05$ ).

**Table 5.17 Use of Merchant's Quay Project Services**

Merchant's Quay Services	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Health Promotion Unit	81	(25)	53	(10)	70	(35)
Contact Work	58	(18)	84	(16)	68	(34)
Acupuncture	42	(13)	47	(9)	44	(22)
Massage	13	(4)	42	(8)	24	(12)
Art Room	25	(8)	42	(8)	32	(16)
Nurse	58	(18)	79	(15)	66	(33)
Phone	64	(20)	84	(16)	72	(36)
One-to-One Counselling service	35	(11)	53	(10)	42	(21)
Stabilisation	19	(2)	17	(3)	18	(5)
Residential	3	(1)	17	(3)	8	(4)

## 5.8 HEALTH AND WELL-BEING

Respondents were asked in some detail about their health and well-being. Included in this section were three questions that were specifically concerned with participants sexual behaviour. All clients were asked whether they were sexually active. **Figure 5.15** shows that the majority of respondents (69%) reported being sexually active. Just under half the respondents reported having a regular sexual partner, and 20% of the clients stated that they were sexually active, with no regular sexual partner. Female respondents were proportionately more likely to report having a regular sexual partner. Sixty three percent of female clients reported this compared with 39% of their male counterparts. Although not statistically significant, respondents who reported being sexually active were younger than those who reported not being sexually active. The average age of those who reported being sexually active was 23.6 years compared to an average age of 25.8 years for those who reported not being sexually active.



All respondents were asked about their condom use. **Table 5.18** illustrates that only one quarter of the sample group reported using condoms all the time, and 49% reported never using condoms. There was no significant gender difference in reported condom use, but Table 5.18 illustrates that the female respondents were proportionately more likely than their male counterparts to report never using condoms.

**Table 5.18 Condom Use**

Condom Use	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Always	27	(8)	21	(4)	25	(12)
Sometimes	27	(8)	26	(5)	26	(13)
Never	46	(14)	53	(10)	49	(24)

\*Missing Observations = 4

Respondents were also asked in some detail about both their physical and mental health. Firstly they were asked to give a global subjective rating of their physical health and mental well-being. **Table 5.19** shows that 10% of the respondents stated that their physical health was very good, and a further 14% stated it was good. On the other hand, 24% of respondents stated that their health was poor. Regarding mental health, Table 5.19 illustrates that 22% of respondents stated that their mental health was poor. Although not statistically significant analysis revealed that female respondents were proportionately more likely to report that their physical health was poor compared to their male

counterparts. Thirty percent of the female respondents reported poor health compared with 19% of male clients. Likewise female respondents were more likely than their male counterparts to report that their mental health was not good. Thirty six percent of female clients reported that their mental health was poor, compared with 13% of the male respondents.

**Table 5.19 Health and Well-Being**

Rate Health	Physical		Mental	
	%	<i>n</i>	%	<i>n</i>
Very Good	10	(5)	4	(2)
Good	14	(7)	32	(16)
Fair	42	(21)	38	(19)
Poor	24	(12)	22	(11)
Very Poor	10	(5)	4	(2)
<b>Total</b>	100	50	100	50

Participants were also asked whether they suffered from a range of physical and mental health complaints. **Table 5.20** illustrates that over one third of the respondents reported that they had abscesses. Reported levels of overdose both accidental and deliberate were relatively low at 12% and 8% respectively. Table 5.20 shows that there were some notable gender differences in reported health complaints. For example, although not statistically significant the female respondents were proportionately more likely than their male counterparts to report weight loss, abscesses, and having hepatitis B and C.

**Table 5.20 Physical Health Complaints by Gender**

Health Complaints	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Abscesses	29	(9)	47	(9)	36	(18)
Septicemia	0	(0)	0	(0)	0	(0)
Accidental Overdose	16	(5)	5	(1)	12	(6)
Deliberate Overdose	10	(3)	5	(1)	8	(4)
Weight Loss	52	(16)	68	(13)	58	(29)
Hepatitis B	10	(3)	16	(3)	12	(6)
Hepatitis C	45	(14)	63	(12)	52	(26)

**Table 5.21** illustrates that levels of reported mental health complaints were high. Over three-quarters of the respondents reported suffering from depression, although not statistically significant, women were proportionately more likely to report this than the male respondents. Fifty eight percent of the respondents reported feeling unable to cope and half also reported feeling isolated. Table 5.21 also shows that female respondents were proportionately more likely than their male counterparts to report suffering from all the mental health complaints. This may be due to a real gender difference, conversely it may be due to the fact that women are more likely to admit suffering from such conditions.

**Table 5.21 Mental Health Complaints by Gender**

Health Complaint	Male		Female		Total	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Depression	71	(22)	89	(17)	78	(39)
Anxiety	52	(16)	37	(7)	46	(23)
Unable to Cope	45	(14)	79	(15)	58	(29)
Isolated	42	(13)	63	(12)	50	(25)

The majority of respondents (87%) reported that their health had changed since being out of home,

and more specifically that it had deteriorated since being out of home. **Figure 5.16** presents some of the comments made about their health as a result of being homeless.

**Figure 5. 16 Changes in Physical Health**

<p><i>"I'm not eating proper food, I eat chocolate all the time now"</i> – 21-year-old staying with friends</p>
<p><i>"I'm not eating anything at all. My skin keeps breaking out in spots and I feel really weak all the time"</i> - 22-year-old female staying with friends</p>
<p><i>"I've lost a lot of weight"</i> - 32-year-old male staying in a hostel</p>
<p><i>"It was very bad the last time I was on the streets, I'm not going to let that happen again, I hope to God"</i> – 18-year-old male sleeping rough</p>
<p><i>"I'm always sick now, I just seem to have a cold all the time"</i> – 24-year-old male staying in a hostel</p>
<p><i>"My health has got really bad, because I am not eating anymore, and I'm not looking after myself as well as I used to"</i> – 22-year-old male staying with relatives</p>
<p><i>"I used to be quite fit, now my general health has gone right down"</i> – 29-year-old female staying in a hostel</p>
<p><i>"I'm pregnant again, and really run down, I just feel completely broken down"</i> -23-year-old woman staying in B+B</p>
<p><i>"I'm just really run down from not eating properly, if I was at home I would be better looked after"</i> –18-year-old female sleeping rough</p>
<p><i>"My physical health is really bad, and I'm very depressed because I have no sense of purpose in life"</i> – 25-year-old female staying in B+B</p>
<p><i>"I've lost loads of weight and have been in hospital twice with IV related problems"</i> – 23-year-old female staying with friends</p>
<p><i>"Since being out of home I've contracted hepatitis C"</i> –18-year-old male staying with friends</p>
<p><i>"Because of lack of proper sleep and food I get sick much quicker now"</i> – 22-year-old female staying in hostel</p>

Finally respondents were asked about their contact with medical services. Over half the clients 57% reported that they had a medical card. Although not statistically significant female clients were proportionately more likely to report having a medical card than their male counterparts. Sixty eight percent of the female clients reported holding a card, compared with 50% of the male respondents. Analysis revealed that female respondents were significantly more likely than their male counterparts to report contact with medical services in the previous three months ( $\chi^2=5.0$ ;  $df=1$ ;  $p<0.5$ ). Ninety five percent of the female clients reported some type of medical contact, compared with 68% of the male clients. **Table 5.22** presents a breakdown of the type of contact by gender. Over half the clients reported having been to see a G.P in the previous three months, and 44% attended a hospital casualty department.

**Table 5.22 Medical Contact by Gender**

Medical Contact	Male		Female		Total	
	%	n	%	n	%	n
G.P.	45	(14)	63	(12)	52	(26)
Dentist	6	(2)	10	(2)	8	(4)
Casualty	29	(9)	68	(13)	44	(22)
Other medical services	13	(4)	21	(4)	16	(8)

## 5.9 CLIENT COMMENTS

At the end of the interview all participants were asked what changes they would like to make to their life at the moment. **Figure 5.17** presents some of the comments made by the clients.

**Figure 5.17 Client Ambitions**

<p><i>“I just want to be normal, and be a good dad to my son. If somebody would give me a chance I’d be able to do it” - 28-year-old male staying in a hostel.</i></p>
<p><i>“I’d like to get clean, get a job, find suitable accommodation and to become “an ordinary individual”. To do this I need an address for job applications” -27-year-old male staying in a hostel</i></p>
<p><i>“I want to get straight in the long term, but right now I want to get my own place and get back to work. I need help and support from services to do this, and I have to face my problems” -32-year-old male staying in hostel</i></p>
<p><i>“I want to have a bed to lie in at night, and to eventually get back to work” - 18-year-old female sleeping rough</i></p>
<p><i>“I want to get out of this hostel and find somewhere secure and safe to stay” - 25 year old female staying in a hostel</i></p>
<p><i>“I want to get my own flat. To get one I need the same rights as everyone else, like dole. I need money as well, so that I can have cash there for the landlord so they can’t give the flat to anyone else” - 34-year-old male sleeping rough</i></p>
<p><i>“I want to get a home for myself and my three children. I need someone on my side to push for me to get accommodation” - 23-year-old female sleeping rough</i></p>
<p><i>“I want to start a new life over again, but don’t know how to do that” -34-year-old male sleeping rough</i></p>
<p><i>“I’d like to get off drugs and get a flat of my own. I need to wake up and get my act together, I have to want to do something with my life it’s not just going to happen” -21-year-old female staying in a hostel</i></p>
<p><i>“I want to get off drugs, settle down and have a family. So I need to get off drugs, find a nice lady and get a nice house” - 24-year-old male staying in a hostel</i></p>
<p><i>“I want to live a normal life in doors” -25-year-old male sleeping rough</i></p>

## 5.10 INDIVIDUAL CLIENT EXPERIENCES

Although the quantitative data presented in this chapter can provide an insight into the extent and nature of homelessness among drug users, its examination across variables loses sight of the individual context within which homelessness occurs. Recognising that both the homeless and homeless drug users in particular are not a homogenous group, there is a need for qualitative Irish research, so as to allow these individual experiences to be examined. This is not an attempt to provide a qualitative analysis of homelessness rather it is one way of demonstrating the social exclusion experienced by individuals.

Each respondent who participated in this research study has their own individual story of their experiences of being an 'out of home' drug user. Two client stories are presented below which illustrate the difficulties of their current situations. In order to ensure confidentiality and protect the anonymity of the respondents all names have been changed.

### Client A

*Sue is sixteen and has been living in a hostel in the South Inner City of Dublin for the past four months. She left school at thirteen by which time she had already started using drugs, primarily hash. Within two years she had begun to use heroin, and by the time she presented at the Contact Centre she had been injecting it daily for five months. Sue did not only use heroin, as she also took anything that was available to her, mainly Cocaine.*

*At fifteen she left her parents home as a result of frequent family rows. As Sue said 'a row breaks out and I get kicked out'. She said that she has been in and out of the family home for the last year. She has stayed in hostels thirteen or fourteen times. She has also spent some time with friends and has been forced on occasion to sleep rough. Sue says that when living in a hostel she tends to share spoons and filters with the others living there. She says that she is sexually active and only uses condoms sometimes. She has poor physical health, has lost a lot of weight, and has problems breathing. In addition she says that she is Hepatitis C positive.*

*Sue misses her family and it makes her feel very depressed and isolated at times. Her ideal accommodation would be her own place, somewhere to call 'home'. Sue knows that she is she too young to get her own place. For the moment, she would like to get her drug use under control and maybe obtain a place on a methadone programme.*

The above story outlines the pathway from drug use to homeless experienced by the respondent. It highlights the fact that the homeless women as a group are getting younger and are engaging in both injecting and sexual risk behaviour. The sharing of injecting equipment and injecting paraphernalia as stated by the respondent could be highly influenced by the accommodation type of the individual. In other words, living in a hostel with other injecting drug users increases the level of risk behaviour experienced by the individual.

## Client B

*John is thirty-four and from Dublin 8. At night, he sleeps rough and he has been living like this for nearly four years. He first became homeless at 12 years of age and so far this has been his longest period of homelessness. The last place he thought of as home was his rented flat where he lived with his partner and four children. He had no choice but to leave his 'home' due to the fact that his drug use had become more frequent and out of control.*

*At 28 he started injecting heroin and has been doing so for the last six years. He injects heroin four or more times a day and he also injects Valium. By sleeping rough, he says his drug use has increased as he can use more often on the streets than when he was living with his partner and kids. John gets most of his money from begging and robbing when he needs to. He says that although it can be very cold, he likes living on the streets as he can earn a lot of money to help him pay for his habit. However, he gets very lonely being on his own especially when he wakes up on Christmas Day alone and think of his kids. He suffers from abscesses, weight loss and hepatitis C.*

*John states that he would love to have his own place again so he could see his kids more often. He has previously served a sentence and is currently on temporary release. He feels that his criminal record will prevent him from getting a job. Having left school at 11 years of age he feels he needs to return to do some course 'to improve' himself' especially his literacy skills.*

The above story highlights that the social isolation and loneliness experienced by the respondent as he sleeps rough at night. Homelessness does not exist on its own, the intrinsic relationship between homelessness and criminal activity, and drug use further excludes the individual from society. It is important to recognise that any response to homelessness and drug use must treat the individual rather than merely concentrating on alleviating their current sleeping arrangements.

## 5.11 DISCUSSION

The data presented in this chapter provides a detailed examination of the circumstances and experiences of a sample of homeless drug users. One in every 2.5 homeless drug users interviewed were female. This is a particularly high gender ratio when one considers that women were not actively targeted for inclusion in the study. This is not to suggest that one in every 2.5 female drug users are homeless, but rather it indicates that women account for a significant minority of out of home drug users. The data in this chapter supports the international research, which indicates both a growing number of female drug users (Ettorre, 1992) and an increase in female homelessness (Kemp, 1997). This is of particular concern as the women interviewed were younger than their male counterparts. Female respondents were on average 22.8 years, while male clients were on average 25.5 years.

The data included in this chapter indicates that approximately one in four of the homeless clients interviewed were rough sleepers. These figures are high considering that the interviews were



undertaken in the winter months when the levels of visible homeless are known to be lower. A similar proportion of clients reported staying in hostels. Analysis revealed that many of the rough sleepers and hostel dwellers utilise other services which cater specifically for the homeless. In addition, almost a third of the client group reported staying with friends and relatives. As discussed in the previous chapter, this group of homeless persons are often excluded from research, yet the data in this chapter illustrates that they represent a significant minority of out of home drug users. Furthermore, this client group does not avail of many of the services available to them in both the statutory and voluntary sector.

For many of those interviewed their current out of home experience was not their first. Fifty nine percent of the respondents reported that they had previously being homeless. This illustrates the transient nature of homelessness among out of home drug users in this study. Although it is purely a subjective measure, the majority of homeless drug users attributed their homelessness to their drug use. However, as illustrated in Chapter Two, there are numerous structural causes to homelessness, which exist independently of an individual's awareness of such causes. These can often remain obscure to the person even after they have become homeless. In other words, a drug user is more likely to directly attribute their homelessness to their drug use, which no doubt is a contributing factor, rather than to the current housing crisis.

Some of the main features to emerge from the data relate to the following; risk behaviour, lifestyle factors and health and well being. Although these features are not exclusive to homeless drug users, they are nevertheless experienced with greater intensity by this group of 'vulnerable' clients whose current sleeping arrangements place them in a far more precarious situation.

*Lifestyle Factors:* In examining drug use and homelessness, it is important to recognise the environmental context within which this social problem is situated. Homeless drug users are characterised by indicators of social deprivation, such as, early school leaving, high criminal records and high unemployment rates which, although similar to those of the drug using population in general, are however further compounded by the presence of insecure housing. Seventy one percent of the clients left school before the school leaving age of 16 years. In addition certain activities such as robbing, begging and prostitution seem to provide the most common way of securing a source of income. Thirty two percent of the respondents stated that their main source of income was robbing, a further 16% stated begging, and 8% reported prostitution. Research has indicated that the relationship between economic deprivation and criminal activity is very strong, in that certain individuals first commit 'survival' crimes (e.g soliciting, shoplifting) and then proceed to 'lifestyle' crimes (possession of drugs) which are part of an increased likelihood of criminalisation (Carlen, 1996). This is supported by the fact that fifty percent of clients reported that they had served a prison sentence, and 50% also reported being remanded in prison.

*Risk Behaviour:* International research has illustrated that homeless drug users who inject in public places and with others are significantly more likely to engage in an overall higher level of risk activity, due to their unstable accommodation (Klee and Morris 1995, Donoghoe *et al* 1992). In this study, sixty six percent of respondents reported injecting in a public place. Furthermore, analysis revealed that clients current sleeping arrangements was related to whether clients reported injecting in public places, in that, rough sleepers were significantly more likely than those in other forms of homeless accommodation to report injecting in public places. Moreover, over half the respondents who reported sleeping rough (54%) and staying in hostels (57%) stated that they usually injected in a group. Forty nine percent of clients reported that they had shared injecting paraphernalia in the last four weeks. Regarding sexual risk behaviour, sixty nine percent of clients reported being sexually active, of which forty nine percent of respondents reported never using condoms. In addition, the respondents who reported being sexually active were younger than those who reported not being sexually active. In short, the data in this chapter highlights that out of home drug users by virtue of their homeless status engage in high levels of both injecting and sexual risk behaviour. Moreover levels of such behaviour vary depend on sleeping arrangements which has immense implications for the type and nature of resettlement services provided.

*Health and Well-being:* The data in this chapter also provides considerable insight into the health and well-being of clients. As discussed in Chapter Two, compared with the general population homeless persons are more likely to have health problems. Research in the U.K had indicated that more than one third of people in hostels and B&B's and well over half of the people sleeping rough reported more than one health problem compared with a quarter of the general population (Bines, 1997). At the same time, the client group by virtue of their drug use are doubly disadvantaged in that they are at greater risk of a range of physical health complaints, such as, abscesses, septicemia, and hepatitis B and C (Power *et al*, 1988). To this end, it is not surprising that 64% of respondents reported suffering from either hepatitis B or C compared to the figures among the total group. However looking specifically at Hepatitis C, the fact that one in two of the homeless clients are aware of having Hepatitis C and continue to engage in high risk behaviour is of great concern.

Regarding mental health complaints, there has been an extensive amount of research illustrating the prevalence of mental illness among the homeless. For example, Anderson et al (1993) illustrated that eight times as many people in hostels and B&B's and eleven times as many people sleeping rough reported mental health problems compared with the general population. This study revealed high levels of mental health complaints among the homeless drug users. For example, three in every four clients interviewed reported that they suffered from depression. No doubt among this client group, their homeless status adversely effects both their mental and physical health. Finally, as in other research there were considerable gender differences in relation to both the physical and mental health of clients. Female respondents were proportionately more likely to report that both their physical and mental health was poor compared to their male counterparts.

# CHAPTER SIX

## CONCLUSIONS AND RECOMMENDATIONS

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### 6.1 CONCLUSIONS

Both national (Cullen, 1997) and international research (Pearson, 1991) has highlighted that the experience of problem drug use is not randomly distributed across the population, but rather it is highly socially patterned. It occurs disproportionately in areas adversely affected by high levels of social deprivation and social exclusion. Such areas are characterized by low levels of educational attainment, high unemployment rates (Pearson, 1991), high crime rates (Parker, 1998), 'run-down' environments (Sibley, 1995) and social instability. Similarly, the experience of homelessness can be located within this poverty laden social context. Not surprisingly, the gradual increase in the number of homeless in Dublin (due to the structural forces identified in Chapter Two), has most acutely affected those of a 'vulnerable' nature and are already excluded from mainstream society. To this end, one would expect homelessness to increase disproportionately among for example, the drug using population. While this may be the case and has been known anecdotally among both drugs and homeless service providers for some time, the lack of research has prevented any independent evidence of this.

This study has shown high levels of homelessness among a sample of problem drug users. A massive 93% of the 190 individuals interviewed reported having experienced homelessness at some point in time and 63% reported being homeless at the time of interview. These figures are not indicative of the extent of homelessness among the entire drug using population. As stated previously, they apply to a specific group of drug users, in that, they are chaotic drug users, who utilised the Merchant's Quay Project and agreed to participate in the study. Regardless of the self-selecting nature of the sample, these figures illustrate unacceptable high levels of homelessness among the population of chaotic drug users. This may not be that unusual as a study of a similar low threshold drugs service in London, which utilised a similar definition of homelessness illustrated that 84% of their new presenters were classified as being homeless at the time of first contact (Flemen, 1997). Homeless drug users present with very complex needs; in that not only do they highlight a group who are highly socially excluded by their drug use but in addition experience insecure housing arrangements which has been shown to adversely effect drug use (Donoghoe, *et al*, 1992). For most homeless drug users, accessing stable accommodation is an immediate priority. It is argued that only when stable accommodation is secured can a drug problem be addressed. Lack of secure housing arrangements can have immense implications for an individual's drug using career, in terms of risk behaviour, access to treatment, relapse prevention and success of recovery.

While the results of this research apply to a very specific client group, and cannot be generalised, they nevertheless provide some valuable, yet basic, information on homeless drug users. There is a need for in-depth research on the extent of homelessness among drug users, and a thorough examination of its consequences. Only when the extent and nature of the problem has been identified, can an all inclusive drug policy be implemented.

## 6.2 RECOMMENDATIONS

The results presented in this research study provides numerous recommendations for each of the following key players; drug service providers, homeless service providers and housing providers. In order to respond appropriately to the needs of homeless drug users, it is essential that each player both individually and collectively attempt to adopt strategies to cope with the increasing number of homeless drug users. This section provides a range of recommendations for drug services, homeless services and housing providers. The implementation of these recommendations will inevitably cost money. If, as a result of the implementation of the recommendations presented here, there is a reduction in HIV or hepatitis infection, the money will have been well spent.

### *6.2.1 Recommendations for Drugs Services*

The manner in which service delivery is undertaken largely depends on the profile of the client group presenting to the service. In view of the fact that 93% of the sample in this study reported having experienced homelessness at some point in time, it is essential that drug workers recognise the extent of the problem and the impact that insecure housing can have on individuals drug use and risk behaviour. In this regard, harm minimisation strategies are of great importance, and should be tailored, in as far as possible, towards the individual client. This would include the following measures;

- **Distribution of Injecting Equipment:** Despite the distribution of sterile injecting equipment, the situational sharing of injecting equipment can still occur due to certain unexpected reasons, for example, having to share due to the confiscation of equipment by police. In such instances, it is necessary to provide the individual with coping strategies to overcome such situations, such as highlighting the importance of forward planning and hygienic injecting practices. In this regard, the liberal provision of injecting equipment including swabs and sterile water to homeless clients in particular rough sleepers, who otherwise would have no access to such materials and consequently engage in high levels of risk behaviour is an essential health promotion strategy.
- **Outreach Services/ Detached Workers:** The provision of outreach services, and/or detached workers to deal specifically with this client group would be valuable. In addition, it is vital that these workers carry emergency injecting packs with them, so as to alleviate any situational sharing that may occur due to the non-availability of injecting equipment. This study has illustrated that 30% of clients reported no contact with any drug treatment service, apart from the Merchant's Quay Project. Recognising this, it is important to target the "hard to reach" of this client group; the 'out of home' drug users who are not currently in contact with drug services or those who may experience difficulty in accessing such services. In addition, the low percentage of respondents reporting methadone as their primary drug may result from clients being hindered from accessing methadone prescribing services by the lack of a fixed address. Where this is the case we recommended that the EHB mobile methadone clinic be made available to homeless drug users who cannot access a methadone programme.
- **Medical Personnel:** Due to the range of physical and mental health complaints experienced by homeless drug users, it is important that each drug service has the presence of medically qualified personnel to provide basic medical care including HIV and TB testing, vaccinations for hepatitis and to make appropriate psychiatric referrals when necessary.
- **Legal Personnel:** Findings of the study revealed that 50% of respondents in the research study had previous experience of imprisonment and that 18% of respondents reported being currently on temporary release. Furthermore, 40% of respondents reported being on bail and therefore had charges pending. In this regard, it is important that skilled legal personnel are available to inform

and deal with the legal matters of presenting clients.

- **Consumption Rooms:** The majority of clients interviewed in this study injected in public places and with other IV drug users. Consequently, they exhibited high levels of borrowing and lending of used injecting equipment. Levels of such risk behaviour did however vary depending on the clients sleeping arrangements, in that, individuals in sheltered accommodation were more likely to engage in more hygienic injecting practices. In this regard, consideration should be given to the provision of a supervised environment, such as a consumption room, would allow safer injecting practices to occur.
- **Training of Drug Workers:** In order to provide a more informed service to 'out of home' drug users, more research is required to recognise the training needs of drugs personnel when dealing with this client group. In this regard, information on welfare entitlements, accommodation options including the procedures in accessing such accommodation and the ability to make appropriate referrals to homeless services, can ensure a more holistic response to treatment.

### *6.2.2 Recommendations for Homeless Services*

Considering the changing nature of the homeless population, and the fact that a significant minority of drug users are contributing to this population, it is necessary that the homeless service providers who deal directly with this client group in their differing capacities, are able to respond immediately. Lack of appropriate stable accommodation impacts on all stages of an individual's drug use. Most notably on risk behaviour, accessing treatment, recovery and relapse prevention. As highlighted in this study the inability to provide accommodation for drug users immediately places them at greater risk of HIV and hepatitis C infection.

- **Increased availability of emergency accommodation:** Emergency shelters and hostels are traditionally seen as providing temporary accommodation with limits being placed on length of stay. However, the current housing crisis has meant that individuals are now regarding hostel provision as a long term sleeping arrangement (Neale, 1997). This in turn has resulted in a process of "silting up" leaving a lack of beds available in the city on any given night. It is recommended that sufficient transitional accommodation be provided to take pressure from emergency hostels, thus freeing up more emergency beds.
- **Increased access to emergency accommodation:** Many hostels restrict admission to particular groups of the homeless population often based on sex or age, and almost always on the drug using status of persons presenting for admission. The result has been a high incidence of rough sleeping among the homeless population in general but particularly amongst homeless drug users. As a direct consequence of this, they are more likely to inject with others in open public places, and more importantly share injecting equipment. Freeing up emergency beds will be ineffective if the rules and regulations of the majority of emergency hostels continue to exclude active drug users from their services. Although homeless services cannot sanction drug use, dealing or possession on their premises, experience from other homeless services indicates that it is nevertheless possible to offer emergency accommodation to active drug users<sup>10</sup>. Indeed, it must be noted that 28% of respondents in this study reported currently staying in hostels.
- **Day Care Services:** In this study, respondents reported one of the main disadvantages of being homeless as having nothing to do to occupy their time and nowhere to go. In such instances, day centres provide a very important service for homeless people including food, advice/information, and training and employment programmes. Recognising that homeless drug users also avail of their services on a regular basis, it is important that all staff can make appropriate referrals to

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<sup>10</sup> A study by Costello and Howey (in print) which examines accommodation options for homeless drug users in England and Scotland highlights this.

drug services, receive information on the safe disposal of injecting equipment and also adapt their services accordingly, for example, the presence of sharps-bins in toilets.

- **Restructuring of Existing Emergency Accommodation:** Homeless service providers need to recognise that drug users do avail of their services, and they do inject while on the premises irrespective of any organisations stated policy. 28% of our sample were staying in emergency hostels. This client group differs from other service users by virtue of their drug use and hence it is necessary that they adapt their services accordingly. For example hostel providers, in the interests of health promotion and harm minimisation could ensure that all rooms have facilities for the safe use and storage of injecting equipment including sinks, bleach and lockers on location if required. In addition, the provision of sharps-bins in hostels for safe disposal of injecting equipment would be welcomed. Hostels providers could also ensure that all key staff have the skills and experience for dealing with this client group. In addition it is important that drug free hostels continue to be available for non drug users and for recovering drug users.
- **Establishment of a Hostel for Homeless Drug Users:** The provision of a direct access hostel to cater specifically for active drug users can have particular benefits for individuals who require medical, social and psychological support in addition to security of housing. Some progress has been made in this regard and the voluntary sector is already attempting to address the needs of this client group. The Simon Community in conjunction with the Merchant's Quay Project are jointly conducting a feasibility study to support the establishment a hostel for chaotic out of home drug users. This identified gap in service provision highlights the inadequacies of the current homeless services in catering for this specific group of the homeless population.

### *6.2.3 Recommendations for Housing Providers*

- **Review of Housing Policy:** The strong link between homelessness and drug use suggests that existing housing policy is in need of review. In recent years we have seen the introduction of the Housing (Miscellaneous Provisions) Act 1997, aimed at facilitating the easy eviction of persons believed to be engaged in drug related anti-social behaviour. In 1998 in the Dublin Corporation Area, there were 44 evictions and 200 house repossessions related to anti-social behaviour.<sup>a</sup> It is suggested that this has contributed to the rise in uptake of emergency accommodation and to the rise in rough sleeping among drug users. We have also seen the creation of "Estate Management Committees" in public housing estates with the power to influence the allocation of housing within their own estates. It can be argued that these measures have directly led to the exclusion of active drug users from public housing. Eviction is a severe and socially harmful sanction. As well as impacting on the individual it also impacts on the providers and users of homeless services, to which evicted persons must turn. We recommend that housing providers work to develop alternative sanctions and supports aimed at minimising drug related anti-social behaviour. We also recommend that homeless individuals presently undergoing or having undergone drug treatment should be made a 'priority group' for housing (without penalising those not in treatment), thus ensuring that they are not further marginalised and socially excluded.
- **Improved Contact with Local Authority Housing Services:** This research has highlighted the lack of contact drug users have with statutory housing providers. For example, less than one in two of the homeless drug users interviewed reported being in contact with Dublin Corporation. Housing providers have a clear role in formulating homeless policy. This does not refer solely to the provision of housing but also to the identification and prevention of structural factors that contribute to homelessness. Ensuring that homeless people can access housing lists via homeless service providers will also ensure greater access to and contact with housing providers.

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<sup>a</sup> Paper from Dublin Corporation to Strategic Policy Committee

- **Supported Housing:** The severe decline in building of local authority houses in the late 1980's and the "right to buy" policy has meant a decline in public housing stock and led to growth in public housing waiting lists. Pressure on social housing and on the private rented sector is hindering people's ability to move out of homelessness and into secure accommodation. It is clear that a range of measures are needed to ensure that there is adequate public and social housing available to accommodate the increasing numbers of homeless persons in Dublin. Considering the chaotic nature of homeless drug users, it must be stated that maintaining an independent home would be difficult for many so supported housing services must also be developed.

### 6.3 TOWARDS AN INCLUSIVE SOCIETY

The provision of accommodation and more importantly a 'home' for homeless drug users depends largely on the co-operation of all key players i.e. drugs and homeless service providers, housing providers, governmental agencies and the individual. An inter-agency approach is needed in order to ensure appropriate and adequate service provision. Substantial additional resources are necessary if we are to minimise risks to the health and wellbeing of homeless drug users. The recent emphasis on promoting social inclusion in Government policy has been welcome and refreshing. Homeless persons and drug users are very much at the margins of our society. Perhaps homeless drug users are the most marginal of all excluded persons. The recommendations above form the basis of a programme of inclusion for homeless drug users. The implementation of these recommendations will represent a major step to the development of a society where the right of all persons to have their most basic needs met is honoured and respected.

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