

Drug Use Among the Homeless Population in Ireland

A Report for the National Advisory Committee on Drugs

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Foreword

I warmly welcome this report from the National Advisory Committee on Drugs (NACD). As Minister of State for both the National Drugs Strategy and Housing, I am conscious of the harm that both drug misuse and homelessness can cause. People who carry the burden of both drug dependence and homelessness are particularly vulnerable. As policymakers, part of the challenge in dealing with this issue is accessing reliable information concerning the nature and extent of drug misuse by this group. It is for this reason that Action 98 of the National Drugs Strategy calls for research to be carried on a number of vulnerable groups including the homeless.

In this regard, the NACD commissioned this report, which had as its overall aim to assess the nature, extent and context of drug use among people who are homeless in Ireland. It was a collaborative project and was carried out by Merchants Quay Ireland with key stakeholders involved in all stages. As the report points out, homeless people suffer from high levels of problematic alcohol and drug use. In addition, over a third had been diagnosed with a psychiatric condition. This group's vulnerability is unquestioned and while I am happy to note that there have been improvements in service delivery over the lifetime of the research, it is clear that the needs of homeless drug users pose a challenge to a number of Government Departments and Agencies.

The research and analysis previously provided by the NACD informs both policy development and best practice in service delivery and this report is no exception. In this regard, the report is timely as it has already fed into the Mid-Term Review of the National Drugs Strategy and will be considered as part of the Homeless Strategy Review.

Finally, I would like to record my appreciation of the on-going work of all of the members of the National Advisory Committee on Drugs, in particular, its Chairperson – Dr Des Corrigan and staff, Director – Ms Mairéad Lyons, Research Officer – Ms Aileen O’Gorman, Mr Alan Gaffney and Mr Declan Crean.

Noel Ahern TD

Minister of State with responsibility for the National Drugs Strategy

Preface

I am pleased to present the findings from the first comprehensive study of drug use and homeless in Ireland "Drug Use Among the Homeless Population in Ireland." This research was commissioned by the NACD in 2002 and undertaken by the Research Unit in Merchants Quay Ireland (MQI) in response to a Ministerial Request and in part fulfilment of our duties in relation to Action 98 of the National Drugs Strategy 2001-2008.

The NACD believe this research will contribute to the development and planning of improved services to homeless drug users. It is clear from the research that homeless drug users are indeed a very vulnerable group. Over a third of the study population were problematic drug users and whilst drug use was not the primary reason for people becoming homeless, it is the key reason for remaining homeless. We noted also that homeless drug users are exposed to higher levels of risk as they use drugs in unhygienic public places and share drug taking paraphernalia. It is worrying that so many problematic homeless drug users injected drugs in the last month many of whom injected alone, which is high-risk behaviour for a fatal overdose. Drug use is combined with alcohol use and a considerable proportion of the sample experienced mental health issues.

The research was implemented under the guidance and support of a multi-disciplinary Research Advisory Group (RAG), comprising representatives from Focus Ireland, Health Service Executive (HSE) Eastern Region, the National Drugs Strategy Team, Dublin Simon, the Homeless Persons Unit, HSE Northern Area (Office of Special Needs and drug counselling), the Homeless Agency and NACD. We are indebted to them for their commitment to mentoring and monitoring this research project. The RAG also considered the findings and advised the NACD in relation to recommendations.

Consequently, the NACD have written to Mr Noel Ahern TD, Minister of State who has not only responsibility for the National Drugs Strategy but also for Housing, advising him in relation to 12 recommendations covering four key areas: policy and planning; drug treatment; harm reduction; accommodation and housing. It is clear that the needs of homeless drug users pose a challenge to a number of Government Departments and Agencies. The NACD is of the view that this Report and crucially our recommendations arising from it should inform and influence the development of improved services and Departmental priorities for this at-risk group.

Finally, the NACD is grateful to Caroline Corr, Marie Lawless and Dermot Kavanagh of MQI for their valuable research work, which was conducted with efficiency and sensitivity. We also acknowledge our indebtedness to the NACD's Director, Mairéad Lyons and to our Research Officer Aileen O'Gorman for their painstaking work in bringing this Report to completion.

Dr Des Corrigan

Chairperson, NACD

Glossary of Terms

National Drugs Strategy The overall aim of the strategy is “to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research”. The Strategy assigns responsibility to the different Departments and Agencies involved in drugs policy under the four pillars of; Supply Reduction, Prevention, Treatment, and Research. Further information can be obtained at www.drugsinfo.ie/nds.htm

National Drugs Strategy Team (NDST) The National Drugs Strategy Team (NDST) comprises of representatives from relevant government departments, voluntary and community sectors. Their primary objective is to implement “The National Drugs Strategy 2001-2008: Building on Experience”.

National Advisory Committee on Drugs (NACD) The NACD was established in July 2000 under the auspices of the Department of Tourism, Sport and Recreation to conduct, commission and analyse research on issues relating to drugs and to advise Government on policy development in the area. Since June 2002, the NACD falls under the auspices of the Department of Community, Rural & Gaeltacht Affairs.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) The European Monitoring Centre for Drugs and Drug Addiction provides European Community members with reliable and comparable information concerning drug use and addiction.

Harm Reduction The principal feature of harm reduction is the acceptance of the fact that some drug users cannot be expected to cease their drug use at the present time and aims, therefore, to provide strategies which can reduce the harmful consequences of drug use, while use continues.

Prevalence This term refers to the proportion of a population who have used a drug over a particular time period. The three most used recall periods are; lifetime (ever used a drug), recent (used a drug within the last twelve months) and current (used a drug within the last month).

Problematic Drug Use This term is used in the report to characterise a level of drug use defined as problematic in accordance with a brief instrument for clinical screening. The Drug Abuse Screening Test (DAST) covers the use of drugs, physical, medical complications, emotional and personal problems arising from drug use in the preceding 12 months.

Dependent Drug Use This term is used in the report to characterise a level of drug use defined as dependent in accordance with a brief instrument for clinical screening. The Severity of Dependence Scale (SDS) provides a measure of dependence which focuses on difficulties in control of drug use, anxiety about use and issues regarding cessation of use.

Problematic Alcohol Use This term is used in the report to characterise a level of alcohol use defined as problematic in accordance with a brief instrument for clinical screening. The Alcohol Use Disorders Identification Test (AUDIT) is designed to screen for a range of drinking problems and in particular for hazardous and harmful consumption.

Bed and Breakfast Accommodation (B&B) B&B accommodation is the term used to describe emergency accommodation which is provided by private owners on contract to local authorities.

Executive Summary

Introduction to the Study

The National Advisory Committee on Drugs (NACD) advises the Government in relation to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland, based on its analysis of research findings and information. The National Drugs Strategy asked the NACD to accommodate the following action within its research programme:

To carry out studies on drug misuse amongst the at-risk groups identified e.g. travellers, prostitutes, homeless, early school leavers etc. including desegregation of data on these groups. It is essential that the individuals and groups most affected by drug misuse and those involved in working to reduce, treat and prevent drug misuse have immediate access to relevant statistical information (Action 98).

(National Drugs Strategy 2001-2008: 123. Dept. Tourism, Sport & Recreation)

Consequently, following open tender, in November 2002 the NACD commissioned the Research Department of Merchants Quay Ireland to carry out a research study on the nature, extent and context of drug use among people experiencing homelessness in Ireland.

Research Objectives

The overall aim of this study was to assess the nature, extent and context of drug use among people who are homeless in Ireland¹. More specifically, the study focused on obtaining;

Quantitative data among the homeless population on:

- The relationship between homelessness and drug use with emphasis on the extent to which drug use contributes to homelessness and the extent to which homelessness contributes to, and exacerbates, drug use;
- The nature and extent of drug use among the homeless population in Dublin, Cork, Limerick and Galway, in particular, types of drug used by age, gender and accommodation type;
- The extent and context of drug-related risk behaviour among the homeless population;
- The needs of homeless drug users and the barriers they encounter in accessing homeless and drug treatment services.

Qualitative data from homeless and drug service providers on:

- Policies concerning homeless drug users;
- The perceived capacity of the organisation to work with homeless drug users;
- The experiences of staff in working with homeless drug users;
- The issues surrounding service provision for homeless drug users;
- The degree of knowledge and training homeless service providers have in relation to drug use and drug service providers have in relation to homelessness;
- The adequacy of services provided for homeless drug users and suggestions for improvement;
- Problems and successes regarding service provision for homeless drug users, and examples of good practice.

¹ Homeless refers to those living in either a hostel/shelter, B&B, squat (e.g., derelict buildings etc.), staying with friends and relatives or sleeping rough. For the purpose of target locations outside of Dublin (i.e., Cork, Galway and Limerick), a broader definition was employed to include transitional housing or long-term supported housing.

Research Methodology

The research study employed both quantitative and qualitative methodologies. In order to achieve the above objectives, data were collected by employing the following data collection measures.

1. **Survey Questionnaire Administered to Homeless Persons:** A survey questionnaire was administered to 355 homeless persons during the period June to October 2003. Nine fieldworkers were recruited and trained for the purpose of quantitative data collection. All fieldworkers had prior knowledge and understanding of the issues involved. None of the fieldworkers were directly involved in the provision of homeless services, in order to ensure confidentiality of information received.
 - The survey questionnaire elicited information on basic identifiers/personal characteristics, accommodation types, experiences of homelessness, health (physical and psychiatric), income, drug and alcohol use, risk behaviours, contact with services (homeless, drug and generic) and self-assessment of current needs and service delivery.
 - Problematic alcohol use was measured by the employment of the AUDIT (The Alcohol Use Disorders Identification Test Screening Instrument) which is a ten-item screening instrument designed to screen for a range of drinking problems and in particular for hazardous and harmful consumption (Saunders *et al.*, 1993).
 - The drug component of the questionnaire followed the EMCDDA template of lifetime, recent and current use of various drug classifications. This was complemented by the following drug use scales:
 - Drug Abuse Screening Test (DAST) – a ten-point scale, which is used to identify problematic drug use;
 - Severity of Dependence Scale (SDS) – a five-item scale designed to measure the degree of dependence on a variety of drugs, including heroin, cocaine, amphetamines, and methadone.
2. **Focus Groups with Service Providers:** During July and August 2003, fourteen focus groups were conducted with a purposive sample of 64 homeless and drug service providers. Eight focus groups were undertaken within Dublin and two focus groups were undertaken in each of the other cities (Cork, Galway and Limerick). Each focus group represented a different aspect of service provision (e.g. low threshold services/open access services, accommodation services, prescribing services, settlement services, drug free services, services for under-18s etc.). The focus groups were co-ordinated and facilitated by the Research Officers at Merchants Quay Ireland.
 - The interview schedule for the focus groups consisted of four main sections: background information on organisations, service users' characteristics and circumstances, policies, procedures, examples of good practice and finally strengths and weaknesses in service provision for homeless drug users.

Summary of Research Findings

Homeless Population – Profile of Research Participants

A total of 355 individuals experiencing homelessness agreed to participate in the survey questionnaire element of the study. In accordance with the tender specifications, the majority were from the Dublin homeless population (n=247; 70%), with the remaining participants (n=108; 30%) recruited from Cork, Galway and Limerick, 36 individuals respectively. In view of the differing sampling methods employed, demographics of the research population (gender, age, accommodation type) are not comparable across locations. However, the overall participant profile of the study can be presented as follows;

- Of those interviewed (n=355), 69% (n=244) were male and the remaining 31% (n=111) were female (*dictated by sampling methodologies employed).
- The mean age of respondents was 35 years. Over a quarter of the sample was less than 25 years of age (*dictated by sampling methodologies employed).
- Hostel (50%), B&B (19%) and rough sleeping (16%) were the most common homeless accommodation types (*dictated by sampling methodologies employed).
- The majority of the total study population (89%) were Irish with the remaining 11% largely comprising of individuals from Northern Ireland, England, and Scotland.
- The majority of respondents identified themselves as single (78%). Only 10% of the study population were living with children (under 18 years), of whom half were living alone with children in their accommodation.
- The largest proportion of individuals in the Dublin sample reported their last permanent address as being in the South Dublin suburbs (D.22 & D.24; 17%), the North Inner City (D.1 & D.7; 14%), and the South Inner City (D.2 & D.8; 14%). Seven percent (n=16) of respondents reported their last known address as being in the UK.
- Respondents demonstrated low educational attainment and poor economic status. Only 6% of the overall study population reported having reached higher education and a further minority of the sample were in employment (regular or occasional). The majority of respondents were dependent on government benefits.
- Over half of the total study population reported previous experience of imprisonment. Analysis revealed that male respondents were significantly more likely to report having been in prison than their female counterparts.

Nature, Extent and Context of Drug Use among the Homeless Population

The following summary provides an overview of the nature, extent and context of drug use among those experiencing homelessness in Ireland, in addition to some of the main findings relating to risk behaviour, health, policy and service responses to drug use. The information presented refers to data collected from members of the homeless population (n=355) and homeless and drug service providers (n=64).

Homelessness and Drug Use

- Personal drug use (n=67; 19%) was cited as the second most common reason for becoming homeless. Thirteen percent reported personal alcohol use (n=44). Alcohol use as a primary reason for becoming homeless was higher in Limerick and Galway (22% and 17% respectively) in comparison to 11% in both Dublin and Cork.
- The majority of those experiencing homelessness first used drugs before becoming homeless (87%). Those that used drugs before becoming homeless reported a younger age of first drug use (15 v 24 years).

Prevalence

- Alcohol remains the primary drug of choice among the homeless population (70%). Frequency of alcohol consumption varied by gender and age. A greater proportion of males reported alcohol consumption in excess of four times a week in comparison to female respondents. Furthermore, those who reported alcohol use in excess of four times a week were older.
- Service providers similarly perceived alcohol to be the main drug of use among homeless people in each city location. However, service providers have noticed a recent change, with alcohol use becoming part of more complex drug using repertoires.
- In terms of accommodation type, those staying in squats and sleeping rough reported a higher frequency of alcohol consumption in terms of use in excess of 4 times a week. Over half of the rough-sleeping sample were problematic alcohol users (52%).
- Nearly three-in-four homeless individuals reported lifetime use of an illicit drug (74%). Cannabis was the most reported lifetime drug (69%).
- Cannabis is the primary illicit drug of current use among the homeless population (43%). Almost a quarter are currently using heroin (22%).
- The majority of current drug users reported use of more than one drug (72%). Overall, this represents 17% of the Dublin homeless sample. Over a quarter of rough sleepers reported the use of five drugs or more (26%).
- Dublin had the highest percentage of current illicit drug users (59%). Findings revealed a 30% current heroin prevalence rate among the Dublin homeless sample. This is in comparison to only very limited current use in Galway and Limerick and no use among the Cork sample.
- A quarter reported current use of sedatives (n=90; 25%), almost a fifth reported anti-depressants (n=67; 19%) and tranquilisers (n=58; 16%). Use of tranquilisers and anti-depressants were also higher among B&B occupants than was observed among hostel dwellers or rough sleepers.
- Nearly one-in-two hostel dwellers in Dublin reported current use of an illicit drug (48%), while over two thirds (n=44; 69%) of B&B residents were current illicit drug users.
- Higher rates of current heroin (34%), cocaine (25%) and crack use (7%) were found among those sleeping rough than among either hostel dwellers or B&B occupants. This finding was also consistent within the Dublin sample.

- Less than a fifth of the total study population reported current methadone use (18%) and over a quarter of them (28%) were not prescribed it. No current methadone use was found among homeless individuals outside of Dublin.

Problematic and Dependent Use

- Among those who consumed alcohol, 73% were problematic drinkers, which represents 51% of the total population. Male respondents reported a higher level of problematic alcohol use than their female counterparts (76% v 63%).
- Over half those staying in hostels (55%) and sleeping rough (52%) were found to be problematic drinkers, while almost two-fifths (39%) of B&B residents were problematic drinkers.
- A third of the hostel dwelling sample and rough sleeping population (32%) scored 20 or above on the alcohol screening instrument which warrants further diagnostic evaluation for alcohol dependence.
- Over a third of respondents (36%) were problematic drug users. There was a much higher proportion of problematic drug users found within Dublin compared to outside Dublin (43% v 19%).
- Problematic drug users were significantly more likely to be younger and report their first homeless episode at a younger age than their non-problematic drug-using counterparts and the overall study population.
- Thirty percent of the Dublin sample indicated a high degree of psychological dependence on the drugs currently used. B&B occupants scored the highest level of dependence (36%) within the total study population, followed closely by rough sleepers (30%).

Risk Behaviour

- Changes in drug using patterns as a result of becoming homeless were reported by over three-in-four current users (77%). Initiation into drug use (for a minority), changes in primary drug and routes of administration, increased frequency/quantity, and associated lifestyle behaviour changes were cited.
- Over a third of the total study population reported having ever injected (35%) increasing to almost half within the Dublin sample (46%). Nineteen percent of the total study population reported injecting heroin in the last month, all of whom were from the Dublin sample (27%). The majority of current heroin users were daily users (52%).
- Fifty-four percent of current injectors were street injectors. Males were more likely to report injecting in public than their female counterparts.
- Almost half of respondents reported that they usually inject alone (46%). Males were significantly more likely to inject alone than their female counterparts.
- Only 26% of current injectors reported not experiencing an injecting related difficulty within the last three months. Scarring and bruising of the injecting site was the most commonly reported difficulty (71%). Almost one-in-three reported abscesses or infections of the site (32%), while one in five current injectors reported accidental overdose in the three months prior to interview (20%). Male injectors were significantly more likely to report not having experienced any difficulties.

Executive Summary

- Over one-in-two current injectors reported sharing injecting paraphernalia in the previous four weeks (53%). Almost one-in-four reported lending injecting equipment (23%) while rates for borrowing were lower at 17%. Injectors were significantly more likely to report lending used injecting equipment rather than borrowing others' equipment.
- Over two thirds of current injectors (69%) reported that their injecting practices had changed as a result of homelessness.

Physical Health

- Higher rates of hepatitis B vaccination were found among problematic drug users than the total homeless population (69% v 40%). Female respondents were proportionally more likely to have received the hepatitis B vaccination than their male counterparts (48% v 36%).
- Over half of problematic drug users were hepatitis C positive (51%) compared to 23% of the total study population. Individuals who had ever injected were also significantly more likely to be hepatitis C positive.
- Headaches, bones and joint problems and dental issues were the most commonly cited physical complaints.
- Problematic drug users reported higher levels of dental complaints than members of the total study population (62% v 43%).
- Problematic drug users reported higher rates for the majority of physical health complaints than was found among the total study population. A higher mean number of complaints was also observed (mean; 5 v 3 complaints). Over a third of problematic drug users reported suffering from 5 or more complaints in comparison to over a quarter of the total study population (37% v 28%).
- Problematic drug users staying in B&B accommodation reported a higher mean number of physical health complaints than problematic rough sleepers or hostel dwellers.
- Problematic drug users were proportionally less likely than members of the study population to report a current medical card (51% v 64%).

Psychiatric Health and Well-Being

- Nearly one-in-two of the study population reported having concerns about their psychiatric health. Less than half of the respondents reported having undergone a psychiatric assessment (42%), while less than a third have been admitted to a psychiatric hospital (n=30%), or diagnosed with a psychiatric illness (n=30%).
- Problematic drinkers were significantly more likely to report having psychiatric concerns than their non-problematic counterparts. While not significant, problematic drug users were proportionally more likely to report psychiatric health concerns than their non-problematic drug using counterparts (50% vs. 40%).
- Prescribed medication was the most common psychiatric treatment cited. Female respondents were proportionally more likely to report prescribed medication than their male counterparts.
- Results found that more hostel dwellers reported having ever undergone a psychiatric assessment

or have being admitted to a psychiatric hospital. This was consistent for the total study and problematic drug using population. However, B&B occupants exceeded hostel dwellers and rough sleepers in terms of ever diagnosed with a psychiatric illness.

Service Provision for Homeless Drug Users

Homeless Services

- The majority of drinkers staying in emergency accommodation reported that staff were aware of their alcohol use (70%), with only one fifth reporting difficulties in accessing emergency accommodation (20%). Difficulties cited suggest that it is more often the behaviour, as a result of consumption, rather than the drinking practice itself, which can cause problems in accessing emergency accommodation.
- Providers of emergency accommodation (with the exception of wet hostels/shelters) reported the operation of a 'no drink policy' however most policies were flexible to accommodate for individual cases. B&B service providers were perceived to be less flexible around alcohol use on premises. Service providers reported that individuals would more likely be excluded for violent or disorderly behaviour rather than use per se.
- Staff awareness of respondents' drug using status was lower than awareness relating to their current alcohol status in all city locations, with the exception of Cork. Almost a third of current drug users staying in emergency accommodation reported difficulties accessing such services due to their drug use (30%). The stigma associated with being a drug user was the most commonly cited difficulty.
- There were high levels of contact with emergency accommodation, drop-in centres and food services. The absence of drug or alcohol users from a homeless service was cited by very few respondents (3% and 1% respectively) as a factor influencing whether respondents attended a particular service or not.
- In relation to contact with homeless services, the results would indicate that problematic drug users, and to a lesser degree problematic drinkers, were more likely to have problems accessing homeless services and more likely to be refused access to homeless services compared to the total homeless population.
- Few of the homeless services interviewed had official policies on illicit drug use, possession and dealing. All agencies interviewed did not allow drug use or drug dealing on the premises but policies around drug-related incidents were more flexible.
- Many of the challenges faced by homeless service providers working with homeless drug users included detecting and recognising drug use, being able to deal with a number of issues simultaneously, addressing their own preconceptions of homeless drug users, fear of dealing with death by overdose, protecting staff and client safety and motivating drug users to address their drug use.
- The general perception among service providers was that homeless services do not adequately meet the needs of homeless drugs users. Barriers faced by homeless services included lack of knowledge and training around drug issues, lack of experience and the negative attitude of some

staff towards drug users, lack of resources and funding restrictions, alienating clients by adopting an abstinence-oriented rather than harm reduction approach and no day service specifically targeted at homeless drug users. In relation to accommodation, service providers questioned the quality of these services for homeless drug users and highlighted the lack of move-on options from emergency accommodation.

- Reference was often made to various homeless service environments not being conducive to an ex-user wishing to sustain a drug free lifestyle. The majority of service providers interviewed felt that specialist services were the most appropriate for homeless drug users, particularly in relation to accommodation. Moreover, they emphasised that any specialist service needed to provide appropriate harm reduction services.
- According to homeless service providers, successful ways of engaging with homeless drug users, which could be built on, included focusing on individuals' behaviour rather than drug use, remaining flexible and promoting multi-disciplinary work. Service providers also recommended that services could be developed in the following ways: increases in resources and funding; development of a continuum of care and settlement plan for homeless drug users; exploration of the feasibility of a safe injecting room; provision of a range of accommodation options including move-on accommodation for drug users in emergency accommodation, additional transitional housing, long-term stable accommodation (through local authorities and private rented) and half way houses.

Drug Services

- Just over a third of the homeless population reported contact with a drug service within the previous three months (36%). Contact with drop-in centres and methadone treatment services were relatively highly reported by one-in-two of those who reported drug service contact. Eighty-five percent of current injectors were in contact with a needle exchange within the preceding three months, representing 17% of the total homeless population.
- During the focus groups, no drug services interviewed reported having a policy on how to deal with homeless clients.
- The main challenges drug service providers reported in working with homeless drug users was trying to meet their multiple needs, engaging with those who did not want to give up drugs, while those working within the confines of an abstinence-oriented model (mainly in Cork and Galway) found it frustrating.
- According to service providers the quality of services offered to homeless drug users was often under-resourced and short-staffed. The lack of needle exchanges in Galway and Limerick and the absence of needle exchanges in the evening and at weekends in Dublin were highlighted as other serious gaps in service provision. According to drug service providers, difficulties homeless drug users had in accessing methadone maintenance treatment included lack of permanent address, waiting lists, keeping appointments, harsh sanctioning for failing urinalysis and the problems in having to attend methadone clinics daily. In relation to treatment, drug service providers felt that there were not enough detox and residential places, the delay between initial assessment and drug treatment put homeless people at risk and the routine and structure of treatment programmes often did not suit homeless drug users. Furthermore, the lack of aftercare meant that homeless drug users were often set up to fail.

- Drug service providers recommended the need for sufficient funding and appropriately trained staff in order to meet the needs of homeless drug users. Some service providers in Dublin highlighted the need for a safe injecting room while those in Galway and Limerick felt needle exchanges should be piloted in different locations in these areas. Service providers advocated that methadone maintenance and treatment programmes should be flexible, less structured, take a holistic approach and assist homeless drug users to access accommodation. Some service providers in Cork and Dublin expressed a need for respite care for homeless drug users as well as aftercare addressing housing, retraining, employment and social support.

Service Needs

- Despite high levels of contact with GPs, hospital clinics, and A&E departments, almost one-in-three homeless individuals reported health care as a service need. Over a third of those who reported contact with GPs were problematic drug users (n = 75, 37%).
- Stable accommodation was reported as the primary service need among respondents (86%). One-in-four respondents reported drug or alcohol treatment as a service need (24%), increasing to 28% within the Dublin sample. Higher numbers of rough sleepers (29%) reported requiring drug/alcohol treatment than hostel dwellers or B&B occupants (23% respectively).

Conclusions

This is the first Irish study undertaken which examines the nature, extent and context of drug use among the homeless population. This study highlights that the causes of homelessness are complex and include both individual/personal and societal/structural factors. For many, drug use was initiated prior to becoming homeless, while for the minority, drug use emerged as a feature of their homeless predicament. To argue that drug use causes homelessness, reduces the complexity of the relationship and simplifies it to merely a cause and effect process with no intervening variables. High levels of licit (including alcohol) and illicit drug use were reported among the homeless population with regional differences in drug use patterns and experiences. Alcohol remains the current drug of choice among the homeless population, with older males reporting the highest frequency of use. Moreover, the research supports the hypothesis that the extent of illicit drug use among the homeless population is substantially higher than it is among the general Irish population. Cannabis is the most commonly used illicit drug. The use of opiates among the homeless population was mainly confined to the Dublin Area. This research has highlighted the importance of lifestyle factors, i.e. appropriate housing among drug users and the impact of their housing arrangements in patterns of risk behaviour. The circumstances in which drug use and drug injecting among the homeless took place were over and above those of personal choice or motivation. Injecting drugs in the streets and other public places was increasingly common among homeless injectors and was often the only viable option for those interviewed. Homelessness was clearly related to a worsening drugs situation. The issue is not that people start to use when they become homeless but their practices and behaviour become more 'risky'. In terms of risk behaviour, drug use and homelessness are clearly interrelated, complicating and exacerbating one another. The social context of injecting practices among the homeless was also more likely to involve contact with other injectors. Over half of injectors reported injecting with others, either with their partner or in a group. Female injectors were less likely to report injecting themselves, and as such, were more likely than male injectors to report communal injecting practices. Homeless injectors exhibited

extremely high levels of injecting risk behaviour (i.e. within last three months), most notably the borrowing of used injecting equipment and the sharing of injecting paraphernalia. The “situational sharing” of injecting equipment and paraphernalia was obvious from individual quotes. Such activities have demonstrated the implications for individual risk behaviour and health concerns with over half of problematic drug users reporting a positive hepatitis C status. The low numbers of problematic drug users who were currently receiving treatment for hepatitis C (11%) must be seen within the a context where accessing hepatitis C treatment can be onerous for individuals in terms of stabilising their drug use. Survey data from those experiencing homelessness and information from service providers substantiate that homeless drug users have numerous complex needs that are not being sufficiently met by existing services. The following points outline a number of implications for policy and service development in order that services develop to meet the needs of homeless drug users.

Policy Implications

1. The findings of the study highlight that there are issues regarding co-ordination of drug and homeless services and joint working relationships between statutory and non-statutory agencies. Results convey that a feature of existing service responses has been the lack of awareness regarding where the responsibility for this client group lies. It is important to ensure a more strategic and partnership approach with clear lines of responsibility and accountability for those working with drug using homeless individuals. Activities relating to co-operation and information sharing have begun but require further consolidation (e.g. a representative of the National Drug Strategy Team has been appointed to the expanded Consultative Forum of the Homeless Agency in Dublin). Support should be given to local drug services inputting into local homeless action plans, while homeless services should be encouraged to participate in local/regional drug task forces. Furthermore, homeless and drug services should work together to implement integrated care and planning in order to meet the needs of homeless drug users.
2. It is important that homeless services take an inclusive approach to drug users rather than exclude them from some of their services. Drug use is not solely an issue for drug service providers. Homeless drug users do, and will, access homeless services. It is important that homeless service responses facilitate homeless individuals who use drugs by providing the following; a continuum of care, a range of accommodation options (ranging from harm reduction services through to drug and alcohol free environments), low threshold drug services, strategies to deal with dual diagnosis and to ensure that all homeless service providers receive drug awareness training.
3. The issue of homelessness among drug users has implications for current delivery and management of drug services. It is important to increase the availability, capacity and effectiveness of drug treatment for homeless persons in Ireland. This could be achieved by the development of more targeted treatment practices for this client group, such as; care planned counselling and support, flexible prescribing options, elimination of waiting lists and time intervals between assessment and entry to treatment, accessible programmes with fewer demands, increased coverage of drug services within homeless services (including drug outreach projects) and tailored peer education and community change programmes for homeless drug users.
4. It is important that homeless drug users can not only access treatment, but that the treatment is effective in retaining individuals and linking them into appropriate aftercare networks. It is

important to approach the treatment of homeless people in a multi-disciplinary, holistic, flexible, non-judgmental way. Pre-treatment services for homeless people would help with the process of engaging in drug treatment by determining the readiness of the individual, offering support around meeting treatment entry criteria, stabilising/reducing drug use and sustaining motivation. Increased retention of the client group in treatment could be enhanced through motivational interventions and active intensive ongoing support, as well as practical measures to encourage attendance and engagement. Furthermore, there is a need to place greater importance on discharge practices and follow-up care, and housing needs assessment should be an integral part of the treatment process.

5. Where homelessness prevails, people are predisposed to a different and more risky style of drug use than would be commonplace among the general drug using population. Measures to reduce harmful consequences could include the following; increased needle exchange coverage for homeless injectors (e.g. pharmacies, outreach workers, mobile services etc.), strategically placed sharps bins (in public places and homeless services), educational strategy regarding polydrug use, respite houses and provision of a supervised injecting facility.
6. Harm reduction should be understood to include all substances both licit and illicit. Given the profile of homeless drug users, it is important that a targeted alcohol harm reduction strategy for members of the homeless population is promoted. As with drug use, abstinence may be unacceptable as a goal for the individual and in such cases, it is necessary to implement strategies which focus on moderation in use and reducing alcohol-related harm.

Chapter One

Introduction

1.1 Background to the Study

The homeless population cannot be classified as a homogeneous group (Neale, 1997a). National and international research refers to a population increasingly made up of a greater proportion of women (Jones, 1999) and a younger, more heterogeneous, group of individuals (Warnes *et al.*, 2003). These groups often present with complex needs as well as high levels of drug/alcohol use (Wincup *et al.*, 2003; Fountain and Howes, 2001; Costello and Howley, 1999; Cox and Lawless, 1999) and mental health issues (Gill *et al.*, 1996; Cleary and Prizeman, 1998; Crowley, 2003).

To date, homelessness and drug use have often been treated as two separate social issues. Homelessness has traditionally been seen primarily as a housing problem while drug use has been viewed as either a criminal matter or as a public health issue. Recently, there has been increased recognition of some degree of overlap between the two problems: homeless service providers have realised that increasing numbers of people using their services are drug users. Similarly drug service providers have been aware that many of their clients are currently homeless or are living in insecure accommodation and are vulnerable to becoming homeless. This association has been further confirmed through research findings and various policy statements in the areas of both drugs and homelessness. International research indicates that homelessness and drug use are connected, yet the nature of this association is uncertain and under-researched.

1.2 Introduction to the Study

The National Advisory Committee on Drugs (NACD) advises the Government in relation to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland, based on its analysis of research findings and information. The National Drugs Strategy asked the NACD to accommodate the following action within its research programme:

To carry out studies on drug misuse amongst the at-risk groups identified e.g. travellers, prostitutes, homeless, early school leavers etc., including desegregation of data on these groups. It is essential that the individuals and groups most affected by drug misuse and those involved in working to reduce, treat and prevent drug misuse have immediate access to relevant statistical information (Action 98).

(National Drug Strategy 2001-2008: 123. Department of Tourism, Sport and Recreation)

Consequently, following open tender, in November 2002 the NACD commissioned the Research Department of Merchants Quay Ireland to carry out a research study on the nature, extent and context of drug use among the homeless population in Ireland.

1.3 Research Aims and Objectives²

The overall aim of this study was to assess the nature, extent and context of drug use among the homeless population in Ireland. More specifically, the study focused on obtaining:

Quantitative data among the homeless population on:

- The relationship between homelessness and drug use with emphasis on the extent to which drug use contributes to homelessness and the extent to which homelessness contributes to, and exacerbates, drug use;

² As defined in the tender and project objectives documents.

- The nature and extent of drug use among the homeless population in Dublin, Cork, Limerick and Galway; in particular types of drugs used by age, gender and accommodation type;
- The extent and context of drug-related risk behaviour among the homeless population;
- The needs of homeless drug users and the barriers they encounter in accessing homeless and drug treatment services.

Qualitative data from homeless and drug service providers on:

- Policies concerning homeless drug users;
- The perceived capacity of the organisation to work with homeless drug users;
- The experiences of staff in working with homeless drug users;
- The issues surrounding service provision for homeless drug users;
- The degree of knowledge and training homeless service providers have in relation to drug use and drug service providers have in relation to homelessness;
- The adequacy of services provided for homeless drug users and suggestions for improvement;
- Problems and successes regarding service provision for homeless drug users, and examples of good practice.

1.4 Key Definitions

For the purpose of this study, the terms “drug use” and “homelessness” will be defined as;

- “drug use” – refers to the use of any licit (including alcohol) or illicit substance, which is consumed as prescribed or non-prescribed medication unless otherwise specifically stated.
- “homelessness” – this term includes those living in either a hostel/shelter, B&B, squat (e.g., derelict buildings etc.), staying with friends and relatives or sleeping rough³. For the purpose of target locations outside of Dublin (i.e., Cork, Galway and Limerick), a broader definition was employed to include transitional housing or long-term supported housing.

1.5 The Report

The following Report outlines the nature, extent and context of drug use among the homeless population in Ireland.

Chapter Two examines both national and international literature in the area of homelessness and drug use. This chapter will also include a review of literature on the profile of the population group, prevalence figures and the multiple and inter-related problems of homeless drug users. The review will highlight 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.

3 The definition of “homelessness” employed for Dublin was based on the HA/ESRI assessments of homelessness 1999, 2002.

Chapter Three outlines the research methods employed in achieving the objectives of the study. The design and implementation of research instruments used in the study are discussed. Site selection, negotiation and access are also covered within this chapter in addition to details relating to the different sampling methods, data management and data analysis techniques employed.

Chapters Four to Eight illustrate the findings of the research study. Both qualitative and quantitative data are presented throughout these chapters. Chapter Four outlines the profile of those who participated in the research project. Chapter Five focuses on alcohol practices of respondents while drug-using patterns and practices are discussed in Chapter Six. Information on risk behaviour and health status is examined within Chapter Seven. Finally, data relating to the service provision for homeless drug users is illustrated in Chapter Eight.

The Report concludes with Chapter Nine which provides a summary of the main findings and presents various evidence-based conclusions and policy implications.

Chapter Two

Review of Literature

2.1 Defining Homelessness⁴

There is no universally agreed definition of homelessness (O'Sullivan, 1996). The definition of homelessness under Section 2 of the Irish Housing Act 1988 includes individuals accommodated within emergency hostels, shelters, bed and breakfast accommodation and those sleeping rough but excludes those involuntarily sharing accommodation with family or friends or living in insecure, inadequate or below standard accommodation (for example, overcrowding)⁵. Collins and McKeown (1992) argue that this legal definition of homelessness is not well formulated as it can be open to varying interpretations of the definition as it excludes the "hidden homeless" (i.e. those living in insecure accommodation) and those at risk of homelessness. Similarly, O'Sullivan (1996) advocates that three categories of homelessness (visible, hidden and at risk) should be used when conceptualising homelessness⁶. Pleace *et al.* (1997) argue, however, that there are a number of problems with the concept of hidden homelessness. Of primary concern is the fact that it can result in all housing needs being referred to as a form of homelessness. Furthermore, many may live in specialist accommodation that is not labelled as accommodation for homeless persons. In 2001, Houghton and Hickey pointed out that those at risk of homelessness should not be ignored by the State as many people experience homelessness periodically. Those needs have recently been acknowledged under the Government Preventative Strategy (2002) and a number of measures have been put in place to reduce the risk of homelessness among these groups. These include allowing people in prison on short sentences to maintain local authority tenancies, including prisoners on housing lists, and special accommodation provision for young people leaving care.

2.2 Counting Homelessness

It has been noted by researchers that the "absence of reliable data on the homeless population represents one of the most significant data gaps in our knowledge and understanding of poverty in Ireland" (Corrigan *et al.*, 2002:51-52). It is particularly difficult to obtain an accurate picture of the number of people experiencing homelessness as they are highly transient, to a large extent relatively "hidden", and from a research perspective, difficult to identify (Dublin Simon Community, 2003). The tendency for members of the homeless population to drift in and out of homelessness makes it difficult to obtain an accurate estimation of the extent of homelessness. There are also issues regarding the accuracy of data upon which estimates of those experiencing homelessness are based. For example, the statutory returns made by local authorities, while accounting for the bulk of the homeless population, only provides information on those who have been bureaucratically accepted and defined as being homeless (Cox and Lawless, 1999). Furthermore, the accuracy of these assessments has been disputed in the past by O'Sullivan (1996) who pointed out that some local authorities reported no homelessness in their areas despite the existence of homeless services there.

4 For a theoretical examination of the term "homelessness" refer to Neale (1997a; 1997b).

5 "A person shall be regarded by a housing authority as being homeless for the purposes of the Act if –

- (a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might be reasonably expected to reside with him, can reasonably occupy or remain in occupation of, or
- (b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources" (Section 2: *Irish Housing Act, 1988*).

6 Visible Homelessness – people sleeping rough or living in designated emergency shelters or bed and breakfasts.

Hidden Homelessness – people who are staying with relatives or friends because of the lack of alternative accommodation or remaining in institutional care because of the lack of affordable accommodation.

People at Risk of Homelessness – people who have housing but are likely to become homeless because of economic difficulties or the threat of violence.

Under the Government's Integrated Strategy on Homelessness (2001) each local authority is now required, in conjunction with the Health Boards and voluntary bodies, to draw up a city or county level plan for addressing homelessness, however there remains "significant deficiencies in the accuracy and sophistication of the data available from local authorities" (Housing Access for All, 2003:20).

Overall, many different methods have been employed to study and count the homeless population (one night counts, street surveys, service-based designs, computerised client-tracking systems etc.) and this can largely account for the variability of results in this area. While such data has its limitations, it is nonetheless valuable in providing some insight into the nature and extent of homelessness.

2.3 Homelessness in Ireland

The Department of Environment estimated that 5,581 individuals were homeless in Ireland during one week in March 2002⁷. This compares to 2,501 homeless during the same period in 1996. Of those who were estimated to be homeless in 2002, 4,060 were in Dublin. Rough sleepers accounted for 312 individuals while the remainder reported staying in emergency or insecure accommodation.

2.3.1 Homelessness in Dublin

The "Counted In" assessments of homelessness (1999; 2002) contain some vital information on the homeless population⁸. These assessments included persons registered as homeless with a local authority during a one-week period and those in contact with a homeless service. The 1999 assessment identified 2,900 adults who were homeless, with the figure remaining approximately the same in 2002, at 2,920. The number of children in families who were homeless increased from 1999 to 2002 by almost 15% to 1,140 (HA/ESRI, 2002). Almost 90% of families who were homeless were staying in B&B accommodation. There was a 13% increase in the number of those sleeping rough from 275 in 1999 to 312 in 2002. However there were various inconsistencies noted between the 1999 and 2002 assessments (HA/ESRI, 2002:5). Corr (2003c) highlighted that they also ignore the hidden homeless who were not in contact with either homeless services or the local authority. Therefore, these assessments have been described as a rather crude and sterile measure as they only include those recognisably homeless during one specific week (Houghton and Hickey, 2001:8). To address this issue the Homeless Agency has developed an internet-based tracking system ('LINKS' system) which is used by homeless services to record service user details and trace service participation on an ongoing basis. However, some concerns have been raised with it (Corr, 2003c).

Different methodologies, which are not always comparable, are employed to measure the number of rough sleepers. The most frequently used methodologies are street surveys which are based on self-reporting and street counts which are based on a head count of people sleeping out. A street count jointly carried out by the Simon Community, Focus Ireland and Dublin Corporation found that the total number of rough sleepers in Dublin city centre during one week in October 2000 was 202, representing a 60% increase on the street count of December 1997 (125 persons sleeping rough) and a 36% increase on the street count of June 1998 (149 persons sleeping rough). Street counts were also

7 According to the 2002 Local Authority Assessment of Social Housing Need, the waiting list for social housing stood at 48,413 individuals. When households living in unsuitable or unfit accommodation are included this figure rises to 56,000 (Cornerstone 2003).

8 The 1999 Assessment of Homelessness undertaken by the Homeless Agency and the ESRI also included counties Kildare and Wicklow.

organised by the Homeless Agency and carried out on one night each in 2002 and 2003. The first count found 140 people sleeping rough, while the second count found 86 rough sleepers. These counts only represent a 'snapshot' on a single night and cannot hope to represent the actual number of people sleeping rough (Cox and Lawless, 1999). Flow or period estimates are more meaningful than one-night counts (Warnes *et al.*, 2003). A recent survey co-ordinated by Dublin Simon, and carried out by homeless organisations along with Dublin City Council in 2004, cited that 237 people slept rough in Dublin City Centre on 4 out of 7 nights (i.e. more than 50% of the time) over a six-week period. This does not include people rough sleeping in the suburbs and the count organisers argued that "figures are unlikely to have gone down, given Dublin City's Council's recent policy of moving people who are homeless out of city-centre locations"⁹.

2.3.2 Homelessness Outside Dublin (Cork, Galway and Limerick)

Outside the Greater Dublin area few prevalence studies have been undertaken. One survey conducted in Cork estimated a homeless population of about 300 in the city (Kearns *et al.*, 2000) while the Local Authority Assessment of Homelessness (2002) recorded 382 homeless persons (Department of Environment, 2002c). Even though there are problems with hostel headcounts (Williams and O'Connor, 1999) they can also give an indication of levels of homelessness. During 1999, 1,094 individuals were admitted on a short-term or crisis basis to Cork Simon Emergency Shelter which was a 40% increase on the previous year (Cork Simon Community, 2000). In 1998, Cork Simon Community recorded that the number of persons staying at the emergency shelter aged 25 and under had increased from 6% of the total hostel population to 22% in a twelve-month period (Frost *et al.*, 2001).

MacNeela (1999) found an estimated 963 people were classified as homeless in Galway in 1998, with approximately 76 people homeless in Galway on any given day. This included between five and twenty people sleeping rough on a given night during the winter months with figures increasing during the summer months. Approximately 41% were men, 22% women and 28% children (information was not available on the characteristics of the remaining 9%). The Local Authority Assessment of Homelessness (2002) recorded 155 homeless persons (Department of Environment, 2002c). According to the 2002 Annual Report by COPE, there was a total of 1,497 people seeking help in 2002 which was an 18% increase in the number of homeless persons seeking assistance in 2001¹⁰. Fifty-five percent of the people were single men, 23% were women and 22% were children (COPE Annual Report, 2003).

Limited research has been undertaken on homelessness in Limerick. In 1999, it was estimated that there were around 16 "street homeless" in Limerick City with a further 139 residing in hostels for the homeless¹¹. In 2001, Focus Ireland reported a record high of 90 single people on its accommodation waiting list¹². Furthermore, in terms of the issue of youth homelessness, 60 young people presented themselves as homeless to the health board in 2001¹³. In view of the recent activities in relation to the prevention and reduction of youth homelessness, it is probable that this does not reflect the current situation. The Local Authority Assessment of Homelessness 2002 carried out by Limerick City Council recorded 88 homeless persons on 28th March (Department of Environment, 2002c).

9 Joint Release by Focus Ireland and Dublin Simon on 22nd March 2004 "Numbers of People Sleeping Rough in Dublin City Remain at High Levels".

10 "Rise in Homeless Seeking Help in Galway" in *The Irish Times*, October 8, 2003.

11 "When There is No Room at the Inn" in *The Limerick Leader*, October 2nd, 1999.

12 Press Release by Focus Ireland July 13th, 2001: "Limerick Housing Crisis on the Increase as Focus Ireland Reports a Record High of 90 People Currently on its Waiting List for Single Accommodation".

13 "Study Warns of Rise in Youth Homelessness" in *The Limerick Leader*, April 20th, 2002.

2.4 Responses to Homelessness

The 1988 Housing Act identified local authorities as the statutory agencies with responsibility for homeless people. Health Boards share responsibility for homelessness with the 1953 Health Act imposing a duty on health boards to provide shelter and assistance to homeless persons and the 1991 Childcare Act giving them responsibility for homeless children. A more holistic policy response, recognising the multi-dimensional nature of the problems which homeless people present with, emerged in 1996 with the establishment of the Dublin Homeless Initiative. It operated under the joint direction of the Eastern Health Board and Dublin City Council, and in partnership with voluntary sector service providers, with the aim of improving the co-ordination, planning and delivery of service provision for homeless people. This innovative partnership approach was cemented in Government policy with the publication of *Homelessness – An Integrated Strategy* in May, 2000 which established partnership structures in every local authority area to bring together the various statutory departments and voluntary agencies to provide a more coherent and integrated delivery of services to homeless persons. In Dublin the Homeless Agency emerged from the Homeless Initiative to manage the delivery of services to people who are homeless in the Greater Dublin area and Homeless Forums were established in other local authorities across the country bringing together statutory and voluntary service providers in locally based partnerships. Three-year “Action Plans” were developed for each area and significant additional resources were set aside by Government to fund these plans.

These developments have led to very significant improvements in the quality and quantity of services available for homeless people in Ireland. As well as increasing the number (providing 900 additional beds) and quality of emergency beds available to homeless people, there has also been significant investment in transitional housing, settlement services, dedicated health care services for homeless people, outreach and drop-in services and also specific innovative new initiatives aimed at meeting the needs of homeless people with drug and alcohol problems such as “wet” hostels and a hostel for active drug users in Dublin which opened in 2001.

2.5 Drug Use in Ireland

The first drug population survey in Ireland and Northern Ireland was carried out in 2002/2003 among the 15-64-year age group. Results showed that almost one-in-five (19%) of respondents in Ireland reported ever taking an illegal drug, with cannabis as the most commonly used (18%). One-in-18 (5.6%) reported drug use in the previous year while one-in-33 (3%) reported use in the previous month. The vast majority of those reporting use of any illegal drug in the last month had used cannabis (2.6%) (NACD and DAIRU, 2003).

“Indirect” methods are more appropriate in estimating problematic drug use. In Ireland, the Capture-Recapture Methodology is used to estimate the prevalence of opiate use¹⁴. Using this method Kelly *et al.* (2003) estimated that there were 14,452 opiate users in Ireland of which 12,444 were in Dublin. This indicates a decrease from the 13,460 opiate users estimated in the Greater Dublin Area in 1996 (Comiskey, 1998).

Treatment figures are another reliable indicator of drug use. The number of cases presenting for treatment in the Republic of Ireland has increased consistently. The National Drug Treatment

¹⁴ The Capture-Recapture Methodology used data from three different sources; the Central Drug Treatment List, the Hospital Inpatients Enquiry Database and the National Garda Study on Drugs, Crime and Related Criminal Activity.

Reporting System showed an increase from 4,865 in 1996 to 6,994 in 2000 (O'Brien *et al.*, 2003)¹⁵. This increase can be attributed to either an increase in drug use, service provision or the numbers of services providing returns (O'Brien *et al.*, 2003).

2.5.1 Drug Use Outside Dublin¹⁶

In a survey on smoking, alcohol and drug use in the Southern Health Board Region¹⁷, Jackson (1997) found that alcohol remained the dominant drug of use in terms of prevalence and problem use. Thirteen percent of men aged 20-24 years reported problematic/dependent drinking. The vast majority (87%) of respondents reported lifetime use of alcohol, followed by cannabis use (17%). Opiate use showed lifetime use of 1% and current use of almost nil. Treatment figures reveal that within the Southern Health Board Area the number of drug users presenting for treatment remained relatively stable in the years 1996-1999. However, there was an increase of 66% in the number of total treatment contacts in 2000 (from 258 contacts in 1999 to 429 in 2000) with over half of those treated receiving treatment for the first time (262) (O'Brien *et al.*, 2002a). In 2000, nearly two thirds of all those receiving treatment (65%) reported cannabis use as the primary drug type with ecstasy use accounting for 15% of contacts and opiate use 10%. There are, however, indications of an upward trend in opiate use. The number of all opiate contacts increased from 14 in 1996 to 41 in 2000 (O'Brien *et al.*, 2002a).

Treatment figures for the Western Health Board Area¹⁸ indicate that despite the fact that the number of total treatment contacts fell from 22 to 14 in the period 1999 to 2000, the number of new treatment contacts remained static and accounted for the majority of those treated (O'Brien *et al.*, 2002b). Ecstasy was the main drug of use, accounting for over half of all treatment contacts in 2000, followed by cannabis. Earlier studies have noted that the use of psychoactive drugs, especially cannabis, ecstasy and LSD is widespread, particularly among young people in the region (Nic Gabhainn & Comer, 1996). However, the low numbers reporting drug use within the WHB area provide a limited analysis of the overall drug patterns and trends outside the treated drug-using population.

Treatment figures for the Mid Western Health Board Area¹⁹ illustrate that the number of drug users presenting for treatment increased from 83 in 1996 to 327 in 2000 with over half of all those presenting each year receiving treatment for the first time (O'Brien *et al.*, 2002c). Nearly three-quarters of all treatment contacts in 2000 were polydrug users. Over half those presenting for treatment reported that cannabis was their main drug (53%) while 27% reported opiates as their main drug of choice. This pattern is largely dissimilar to other regions where cannabis use is closely followed by ecstasy use (O'Brien *et al.*, 2002c). Among new clients, the number of heroin users more than doubled over the four-year period in question (O'Brien *et al.*, 2002c).

2.6 Responding to the Drugs Issue

The recent history of Irish Drugs Policy began with the establishment of a Ministerial Task Force on Drugs in 1995 which produced its first report in 1996 and second report in 1997. As a result of these Reports, a three-tiered strategy to tackle the drug problem was adopted. The Cabinet Committee on Social Inclusion operates at the highest political level to give overall political leadership to national drug policy. At the second tier there is the National Drugs Strategy Team, with representatives from

¹⁵ The National Drug Treatment Reporting System is an epidemiological database on treated drug use in the Republic of Ireland. It is co-ordinated by the Drug Misuse Research Division at the Health Research Board.

¹⁶ Review of information relating to drug use outside Dublin is largely based on the project target urban locations (Cork, Galway and Limerick).

¹⁷ Counties Cork and Kerry.

¹⁸ Counties Galway, Mayo and Roscommon.

¹⁹ Counties Clare, Limerick and Tipperary North Riding.

relevant government departments, as well as the voluntary and community sectors. Their primary objective is to implement the government's drug strategy and to oversee the third layer which comprises of local drugs task forces which operate in fourteen priority areas and which seek to promote a community-based interagency response to problem drug use in Ireland. The Drugs Strategy was developed in 2001 with the publication of "Building on Experience"-the National Drugs Strategy 2001-2008. It aims at a four-pronged response to the issue of drug use, namely; research, supply reduction, prevention and treatment. Actions are categorised under these four pillars with the role of various government departments in achieving these targets outlined accordingly.

Since the introduction of the National Drugs Strategy there has been a huge increase in the number of drug users in methadone-based treatment, from 2,859 in December 1997 to 5,865 in December 2001, to 7,190 in August 2004. In addition, a wide range of locally based initiatives aimed at the re-integration of drug users into local communities have been developed as well as the implementation of various education-based drugs prevention initiatives allied to significant investment in sports and recreational facilities in the areas worst affected.

2.7 Homelessness and Drug Use

There exists a range of structural and individual factors which can be causal, contributory and consequential to homelessness. These include unemployment, poverty, housing shortages, anti-social behaviour, poor health, mental illness, alcohol and drug use, relationship breakdown, and previous experience of institutional care, including prison and psychiatric care (O'Gorman, 2002). However no Irish study on homelessness has used drug use as the main focus of the research. Similarly, homelessness is often presented as a demographic variable in drug research. Kennedy *et al.* (2001) argue that research on drugs and homelessness remains limited due to three main factors. Firstly, available literature largely relates to the young and single, thus ignoring drug use among older members of the homeless population or homeless families. Secondly, research tends to be associated with "problematic" or "chaotic" use among the homeless population rather than "occasional" or "recreational" use. Finally, those who are "roofless" or come in contact with services are more likely to be included in the research, with little data on drug use among the "hidden" homelessness or those at risk of homelessness (Kennedy *et al.*, 2001: 17). Nevertheless, within existing literature there are a number of similar themes which emerge, including prevalence figures, similarities of risk factors and the multiple and interrelated problems of homeless drug users (Kennedy *et al.*, 2001).

2.7.1 Cause or Effect?

There are a number of common risk factors which lead to homelessness and drug use. The risk factors associated with homelessness also tend to trigger drug taking, which also exacerbate other personal difficulties (Fitzpatrick *et al.*, 2000; Kennedy *et al.*, 2001). Regardless of similarities, the relationship between drug use and homelessness is complex. The social selection approach argues that problematic drug users are at high risk of homelessness (Spinner and Leaf, 1992) as homelessness is often the consequence of an individual's resources becoming gradually exhausted (Baum and Burnes, 1993). There is also the social adaptation theory which argues that substance use is often a consequence of homelessness, a means of adapting to life on the streets and coping with the difficult situation (Johnson *et al.*, 1997; Neale, 2001).

These theories however fail to fully demonstrate the nature of the relationship. Other commentators have argued that drug use and homelessness are interdependent and have described the relationship as a cyclical pattern with each reinforcing the other (Hutson and Liddiard, 1994), a web of causation, (Lloyd, 1998) or an interactive meeting point (McCormack, 1997). Regardless of whether homelessness or drug use comes first, numerous research studies have consistently found that the proportion of homeless people who use drugs is significantly higher than in the general population (Forst, 1994; Flemen, 1997b; Seddon, 1998; Horn, 1999; Cox and Lawless, 1999; Cox, 2000).

2.7.2 Prevalence Estimates

Attempts to estimate an overall prevalence rate of alcohol and drug use among the homeless population is likely to result in an underestimation as rates can vary across homeless accommodation types and client profiles (Horn, 2001). Within the areas of homelessness and drug use there exists research on two distinct groups; members of the homeless population who engage in drug using behaviour and drug users who are homeless. The difference lies in the manner in which the issue is perceived and approached from a service perspective. For example, if a person presents at a drug service, he/she is primarily viewed as a drug user, whereby their homeless status becomes ancillary to their drug-using profile. However, presentation at a homeless service suggests the reverse.

2.7.2.1 Drug Use Among the Homeless Population

Information on the prevalence of drug use among the homeless population has consistently highlighted large numbers presenting with 'problem' drug use as well as indications that drug use is increasing. For instance, figures from Australia illustrate that homeless people are 7.5 times more likely to be heroin dependent than the general population (Horn, 1999).

High levels of drug use among young homeless people have been repeatedly reported. Hammersley and Pearl's (1997) study illustrates that among homeless young people in Glasgow, housing issues and drug problems were 'intimately related'. The findings revealed that over three-quarters had used cannabis, hallucinogens or amphetamines and just under half felt they were addicted to these drugs. Carlen (1996) also found high levels of drug use, in that 76% of the 150 young homeless people interviewed in Manchester, Birmingham, Stoke-on-Trent and rural Shropshire had used illegal drugs. Wincup *et al.* (2003), in a study of drug use among 160 young homeless people aged 25 years and under in England and Wales, revealed that 43% were currently taking heroin and 38% crack cocaine. Seventeen percent of the young people interviewed were identified as "problem" drug users²⁰. Flemen's (1997b) study of drug use among young homeless people in London revealed that 88% of the sample (n=700) reported using illicit drugs.

Other studies on the prevalence of drug use among the homeless population have focused on specific groups of the homeless population, for example, rough sleepers. Fountain and Howes (2001) reported that 83% of a sample of rough sleepers in London had used a drug (excluding alcohol) the month prior to interview with almost half having used heroin (47%). A study of rough sleepers in Edinburgh found that more than half of the people interviewed were regularly using illicit drugs with the proportion of those increasing to two-thirds among respondents aged below 26 years of age (Owen and Henry, 2001). An interim evaluation of the Rough Sleepers Initiative (RSI) in Scotland estimated that 34% of RSI clients had difficulties with drugs (Yanetta *et al.*, 1999).

20 Problem use was defined as using heroin, crack or cocaine on five or more days in the past week.

Prevalence of drug taking amongst homeless individuals in Dublin is high with surveys showing figures ranging from 29% to 64% for lifetime use and 26% to 41% for current use (O’Gorman, 2002). A study undertaken by Corr (2003a) among homeless individuals using the information and advice service of Fáilteú (a resource centre for homeless persons within Merchants Quay Ireland), highlighted that the vast majority of service users reported currently using drugs. Of those who reported lifetime use of drugs, the vast majority (85%) also reported the current use of drugs (i.e. within the last four weeks) with 44% of clients currently injecting. Furthermore, 63% of the total sample were polydrug users reporting a range of secondary drugs. In addition, 86% of clients reported having injected drugs at some point during their drug-using careers, a substantial number of whom had commenced injecting between 15 and 19 years (41%). These high figures are not surprising given that Merchants Quay Ireland has services that cater for the needs of drug users.

An analysis of Dublin Simon Outreach contacts undertaken by Howley (2000) highlighted a high prevalence of drug use among rough sleepers. Findings illustrated that in 1999, 25% of the male, and 32% of female contacts, presented with drug problems.

Holohan (1997), in a study on health status and service utilisation of homeless adults in Dublin, illustrated a lifetime prevalence of illicit drug use for over a quarter (27%) of the sample. Feeney *et al.* (2000), in a study of the health of hostel-dwelling men in Dublin, found that 55% reported ever having used drugs, with more than one-third of the overall sample currently using illicit drugs. Almost one-third of the sample had ever used heroin, and 6% were currently dependent on heroin. Condon *et al.* (2001), in a study of the health and dental needs of homeless people in Dublin, revealed that 38% reported ever having taken illicit drugs, of whom 70% had done so in the previous year. Nearly a quarter of the sample (24%) reported injecting drugs. Smith *et al.*'s (2001) study of one hundred homeless women found that almost 45% of the respondents were classified as dependent – all were opiate dependent and all but one were involved in a treatment programme.

In a research study of drug and alcohol experiences among 34 young homeless men and women in Cork, 41% reported the use of illegal drugs (Frost *et al.*, 2001). Cannabis and ecstasy were the most reported drugs of choice with only one respondent reporting the use of heroin. The Cork Simon Emergency Shelter in 1999 observed an increase in the numbers using illegal drugs such as cannabis and ecstasy (Cork Simon Community, 2000). In a study of the health status and health promotion needs of 65 homeless people in the Western Health Board Region, Hourigan and Evans (2003) reported that 42% of those who had used drugs scored 1-2 on the Drug Abuse Screening Test indicating low level of problems, 24% scored 3-5 or moderate level and 35% scored over 6 indicating the need for intensive assessment.

2.7.2.2 Homelessness Among Drug Users

Both national (Cox and Lawless, 1999) and international research (Neale, 2001) have found high levels of homelessness among the drug-using population. Studies suggest that Irish housing legislation, in particular the indirect use of the Housing (Miscellaneous Provisions) Act 1997, has contributed substantially to homelessness among problem drug users (Memery and Kerrins, 2000; Lawless and Cox, 2003). According to the Irish National Drug Treatment Reporting System, the number of clients who reported they were homeless more than doubled over a four-year period, from 114 in 1996 to 305 in 2000 (O’Brien *et al.*, 2003). These figures may underestimate the extent of homelessness among drug users as they are only concerned with drug users in contact with treatment services. Moreover,

it is possible that homeless drug users may provide the postal code or address of family and friends upon seeking to engage in drug treatment, either as a more reliable contact source, or for catchment reasons.

Higher levels of homelessness were found in studies carried out at Merchants Quay Ireland. In an evaluation of their outreach programme, 75% of the 262 drug users met had been homeless at some point during the last year (Corr, 2003b). Furthermore, in a study of homelessness among attendees at Merchants Quay Ireland's Contact Centre, 63% of clients (n=120) reported being homeless at the time of interview, with only 7% of clients reporting that they had never experienced homelessness. Nearly two-thirds of clients (64%) cited drug use as their primary reason for their current homeless status. Fifty-seven per cent of clients also reported that their current drug-using behaviour was a main barrier towards accessing appropriate accommodation (Cox and Lawless, 1999). A survey of all new presenters at the Health Promotion Unit at Merchants Quay Ireland found lower levels of homelessness with 19% reporting that they were homeless (Cox and Lawless, 2000). However, the fact that this study was on first time attendees to the service may underestimate the extent of homelessness.

2.7.3 Homelessness, Drug Use and Risk Behaviour

There is a dearth of literature on the impact that different housing options have upon patterns of drug use and risk behaviour. Nevertheless, the available research indicates that homelessness can have an adverse effect on drug users' injecting risk behaviour and can exacerbate drug use. Homeless drug and alcohol users tend to use more frequently and in less safe ways than their housed counterparts (Klee and Morris, 1995; Cox and Lawless, 1999; Corr, 2003b). The British Home Office reported that in the United Kingdom, over one-third of the homeless population have injected heroin, and one-fifth have injected crack. Furthermore, over 10% are likely to have used someone else's syringe or passed on their own syringe in the last month (Goulden and Sondhi, 2001). Homeless drug users also have a tendency towards polydrug use (Wright, 2002). Klee and Morris's (1995) study of polydrug 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 and consequently lacked the facilities to inject in private. Furthermore, 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 using large quantities of drugs, injecting frequently, passing on used injecting equipment and using others' injecting equipment. The lack of predictable safe and private places to inject, a chaotic and depressing lifestyle, together with increased dependence on peers, can result in a greater likelihood to engage in injecting risk behaviour (Klee and Morris, 1995:841). Horn (2001) similarly includes the lack of a private environment to inject as a possible high risk factor, as the individuals may be under pressure to maximise their "hit". Referring to the drug using patterns of young homeless persons, Henkel (1999:3) argues that their drug use is public, hurried, unsanitary and dangerous.

Needle sharing may be more likely to occur among homeless drug users due to the fact that they are unable to keep quantities of sterile injecting equipment in a safe and secure place (Rogers, 1992). Donoghoe *et al.*'s (1992) study of injecting drug users in the UK found that those who reported recently sharing injecting equipment were significantly more likely to report living in unstable accommodation, such as squats and hostels, than non-sharers. It was also found that living with other injectors was strongly associated with sharing. An American ethnographer noted in one study that

syringes and paraphernalia are shared in homeless street scenes on such a routine basis that risky HIV practices become normalised (Bourgeois, 1999: 2332-2333). Therefore, homeless street injectors are also at increased risk of contracting and transmitting blood-borne viruses (Seddon, 1998; Magura et al., 2000).

Other research indicates a strong association between an individual's homeless status and experience of drug overdose. A 1998 study, which estimated the number of people who were homeless in Australia, revealed that "heroin overdoses treated before hospitalisation" was one of the six variables most highly correlated with the number of people who were homeless (Australian Department of Family and Community Services, 1998). Moreover, this group are also at risk of an overdose going undetected.

2.8 Homeless Drug Users and Service Provision

2.8.1 Treatment Issues for the Homeless Drug User

Accessing drug and alcohol services for homeless clients can be difficult (Pleace et al., 2000; Kennedy et al., 2001; Randall and Brown, 2002; Randall and Drugscope 2002), although these problems are not confined to the homeless population. However, the practicalities of not being able to provide contact addresses while on waiting lists, or programmes, in addition to the mobile nature of the population group, makes receiving treatment difficult (Henkel, 1999). Homeless individuals often lose contact with the geographical area in which they were previously based and this can lead to problems in obtaining methadone and continuing their treatment programme (Howley and Costello, 2001; Horn, 2001). Sustaining engagement with treatment is also a key problem faced by homeless drug users as commitment and motivation are often difficult to maintain (Randall and Drugscope, 2002) and retention problems with homeless clients are equally or more pervasive than in the general addicted population (Orwin et al., 1999: 62). Orwin et al. (1999:63) argue that there are "recognisable periods of increased risk" for the homeless drug user seeking drug treatment particularly at assessment or assignment to the group and the programme commencement.

The importance of securing stable accommodation for those seeking treatment is well established in drugs literature (Seddon, 1998; Neale, 2001; Bessant et al., 2002). A drug dependency further complicates the already insecure position of an individual in need of accommodation (Bessant et al., 2002), as Neale (2001) refers to the "double jeopardy" of being both homeless and a drug user. Residential withdrawal programmes are often the only viable option for the majority of homeless drug users, as the lack of a home and personal support networks makes home-based withdrawal programmes unfeasible (Horn, 2001). It is often the case that the only available accommodation option for individuals who have become drug free or have completed withdrawal programmes is to return to crisis accommodation in which there may be high levels of drug use (Horn, 2001). Similarly, Orwin et al. (1999: 46) argue that;

When homeless clients leave treatment prematurely, they do not merely fail in a treatment episode, but tend also to return to the highly precarious circumstances that precipitated their homelessness.

Seddon (1998) presents secure housing as the immediate priority for homeless people with drug problems and argues that only then can a drug problem even begin to be addressed. In a study by

Wincup *et al.* (2003), homeless service staff reported that the most chaotic drug users were least likely to get rehoused and most likely to have their tenancies discontinued. Homeless drug users are also unlikely to find suitable accommodation to match their high support needs (Rutter, 1998). Henkel (1999:3) argues that to control or reduce the drug use of homeless individuals is 100 times more difficult than when they are safely housed. McCormick (1997:9) states that the drug issue 'becomes itself a central preoccupation in the face of which everything else is put on the long finger.'

2.8.2 Homeless Drug Users and Treatment Effectiveness

While there has been considerable research conducted on treatment effectiveness for alcohol and drug use, relatively little is known about what types of treatment are effective for members of the homeless population. The progress of homeless individuals entering treatment can be impeded by barriers such as poor social support systems, lack of stable sources of income, limited access to low-cost housing and psychological issues (Sosin and Yamaguchi, 1995). Stahler *et al.* (1995) identified several characteristics that were associated with successful outcomes for members of the homeless population six months following treatment; lower recent and lifetime drug use, fewer prior drug treatment episodes, more stable housing, fewer experiences of imprisonment and less social isolation. Stahler *et al.* (1995) argue that even treatment outcomes that were positive seemed to lessen over time indicating the need for extended aftercare. However, Erickson *et al.* (1995), in a follow-up study on homeless, predominantly male, alcohol users, found that greater motivation and readiness for treatment were related to longer programme retention and greater reduction in drug use. An interim report undertaken by Drugscope (2001) on the evaluation of the rough sleepers drug and alcohol specific grants projects in the UK found that;

many of the clients had left detoxification or residential rehabilitation indicating that they may not have been ready for such abstinence-based programmes. The pressure to encourage clients to become drug and alcohol free can result in dangerous practice and it's associated with increased relapse and overdose.

(Drugscope, 2001 cited in Randall and Brown 2002; 39)

Smith *et al.* (1995) compared a residential programme using a therapeutic approach with non-residential services among a population of homeless women with children. Clients within the residential programme were less likely to drop out but the outcomes were similar to those in the non-residential services. Orwin *et al.* (1999) also compared residential with non-residential drug treatment and found that the residential option consistently demonstrated higher retention rates.

The importance of making drug treatment available and accessible to the homeless population by locating it within an already familiar environment, such as a homeless shelter, has also documented favourable treatment outcomes (Miescher *et al.*, 1996). In a US study by Argeriou and McCarty (1993) in which part of a homeless shelter was transformed into a post detoxification stabilisation programme, the rate of success was found to be 63.5% which compared favourably to traditional drug use programmes. According to Argeriou and McCarty (1993), shelters can represent a valuable and cost effective way with which to engage members of the homeless population in drug treatment.

2.8.3 Responding to the Needs of the Homeless Drug User in Service Provision

Limited research has been undertaken with regard to the availability and accessibility of drug services

to meet the needs of homeless drug users within the Irish context. However, there is a consensus within international literature that a growing demand is being placed on homeless services by drug users. The capacity of homeless services to deal with homeless drug users is being challenged by the complexity of their needs. The ability of homeless services to provide effective drug interventions to their clients is often debated by drug services (Randall and Drugscope, 2002). Some homeless services have trained drugs workers while others have generic workers with little specialist training (Warnes *et al.*, 2003). Randall and Brown (2002) argue that specialist substance misuse workers working on the streets and in hostels are better able to negotiate access to services and treatment programmes than non-specialists. Nevertheless, homeless services can play a key role in reaching those “hard-to-reach” drug users who are not in contact with other services (Drugscope, 2001). Homeless services are in a position to provide low-threshold drug interventions and to act as a referral point to more specialist drug treatment services (Drugscope, 2001).

However, the potential for homeless services to act as a “gateway” into more specialist drug treatment services can be hindered by the employment of exclusion policies towards drug users (Randall and Drugscope, 2002). In a Dublin study, Howley and Costello (2001) cited that five of the seven individual homeless projects interviewed reported that drug users were not accepted. Flemen (1997a) argues that individuals are often more likely to conceal their drug-using behaviour or deny themselves much needed assistance from services if exclusion criteria are enforced. It is often the legal aspects of drug use or drug dealing which are of concern to the homeless service provider (Flemen, 2001). Drug use in homeless services has become a matter of concern since the Wintercomfort Case in the UK in 1999²¹. The eviction or exclusion of individuals from hostels and other housing services can perpetuate a vicious cycle as the homeless drug user is maintained in a street homeless situation thereby being also restricted access to other essential services such as psychiatric, health, and welfare services (Seddon, 1998). Neale (2001) feels that homeless services providers have a particularly difficult task in that some former drug users request that current drug users are excluded. The London Drug Policy Forum (1999) argue that separate hostel and supported accommodation should be provided for those who want to continue to use drugs and for those who wish to become drug free. Other commentators advocate the need for a range of accommodation options for people with past or present drug and/or alcohol problems (Randall and Drugscope, 2002; Neale, 2001). Housing providers should also be aware of the vulnerability of drug users and should put strategies in place to prevent tenancy breakdown (London Drugs Policy Forum, 1999). Klee and Reid (1998a) also note that any interventions employed need to take into account the age or level of experience of the drug user. This is particularly relevant for young drug users as it is argued that it is necessary that this group are accommodated appropriately in order to prevent becoming absorbed into a drug-based culture (Klee and Reid, 1998a: 276).

Literature also highlights the need for appropriate accommodation which promotes harm reduction for homeless drug users. Flemen (2001) argues that homeless injectors should have adequate and appropriate access to needle exchange facilities. One recommendation put forward by Flemen (2001) includes locating needle exchange provision within services used by the homeless population, for example within hostels. In this way, a dedicated, private and discrete service could be provided to injecting drug users. If drugs workers of hostels operated needle exchanges, a more intensive and holistic service would be possible. This increased service would help reduce sharing or reuse of equipment and the client group would be diverted away from street-based needle exchanges where their street identities are often reinforced. This could ultimately contribute to changes in lifestyle (Flemen, 2001).

21 In 1999, the Director and Manager of the Wintercomfort Drop-In Centre in Cambridge were jailed for allowing heroin to be traded on their premises. They argued that the confidentiality policy prevented the staff from giving information to the police thereby apparently condoning the activity on the premises. Despite the fact that guidance concerning the legal implications was issued by the Home Office in 2002, there remains insufficient protection for service staff who may not want to address drug users housing needs by exclusion (Hebden, 2002).

Literature has also questioned the ability of drug services to meet the needs of homeless drug users. It is argued that existing models of drug treatment are not designed to meet the needs of the homeless population (Hamilton, 2001). Randall and Drugscope (2002:6) feel that targets for drug services for homeless people should reflect the high level of needs of this group and the likelihood of relapses from treatment. Homeless drug users should therefore be treated as a distinct group (Randall and Drugscope, 2002; Neale 2001; Neale 2002; Hamilton, 2001). This could be achieved, according to Randall and Drugscope (2002) by designing and implementing a special strategy for homeless drug users. This would involve encouraging homeless services to provide services for drug users while also facilitating drug service provision to those experiencing homelessness. Findings from a study undertaken by Neale (2002) revealed that good practice in working with homeless drug users related to five broad areas. These were: staffing, agency environment, support provided, service delivery and agency aims and objectives.

Addressing “lifestyle issues” and dealing with a broad range of social and economic factors that influence an individual’s drug treatment is proposed as current good practice (Kennedy *et al.*, 2001). Orwin *et al.* (1999:63) recommend eliminating unnecessary waiting time and engaging clients immediately by ensuring frequent contact, undertaking active searches for clients who do not make contact and providing tangible items such as food coupons or bus tokens. Sosin and Grossman (2003), in an analysis of empirical work on drug service participation among the homeless population, present two different arguments. Firstly, they argued that general homeless services are lacking, in that they fail to provide adequately for homeless adults “pressing needs”. This in turn means that homeless individuals are more likely to be wary of any other service system (e.g. drug services) and are less likely to participate. The second argument posits the notion that they may avoid drug treatment if it appears to threaten their immediate material circumstances, for example entering drug treatment may require surrendering their hostel accommodation. It may also be the case that tangible benefits, such as finding a bed or food are more important to the individual than seeking drug treatment (Sosin and Grossman, 2003: 524).

2.9 Summary

This chapter has presented a review of the literature in the area of drug use and homelessness. National and international literature demonstrates an acknowledgement and recognition that they are closely associated. Explanations provided within the literature for the nature of this association, and understandings of the pathways into and out of both homelessness and drug use are complex and multi-dimensional. Prevalence estimates of the level of drug use among the homeless population convey that levels of drug use among people experiencing homelessness are higher than the general population (Horn, 1999; Orwin *et al.*, 1999). Many service providers are challenged by the multiple needs with which this client group presents and it is often the case that such individuals fall outside the structures of service delivery which operate an “either/or” approach – either you are homeless or you have a drug dependency (Hamilton, 2001). Overall, research has indicated that drug treatment for homeless individuals can have favourable outcomes. It is particularly successful where access can be flexible and provided quickly, and is developed alongside wider support to ensure that the person’s housing, health and welfare issues are also addressed. Responding effectively requires a more focused and targeted approach from all service providers in which a multiple service system operates (Hamilton, 2001; Randall and Drugscope, 2002).

Chapter Three

Study Design and Methodology

3.1 Introduction

This chapter outlines the research methodology which was adopted to achieve the objectives of the study. As a study of drug use among the homeless population, it was important that the methodology undertaken reflected this approach. Study participants were recruited by nine fieldworkers from a range of homeless services in each of the four city locations, Dublin, Cork, Limerick and Galway. Service providers (drug and homeless) in each city location were also invited to participate in a range of themed focus groups which were facilitated by the Research Department of Merchants Quay Ireland. This chapter examines the research process from the initial preparatory activities through to study implementation and completion. More specifically, stakeholder involvement, site selection, negotiation and access are presented, in addition to details relating to the different sampling methods, data management and data analysis techniques.

3.2 Target Populations

As outlined in Chapter One, this was a national study conducted in four cities throughout Ireland; Dublin, Cork, Galway and Limerick. The two main objectives of the study were;

1. *To gain information (through survey questionnaire) among the homeless population on the nature, extent and experience of those who are homeless and use drugs.*

In accordance with the tender agreement, the majority (70%) of homeless people interviewed were to be targeted within the Dublin area, with the remaining 30% to be recruited in Galway, Limerick and Cork. These non-Dublin locations were selected on the basis of the findings of the 1999 local authorities assessments, as they exhibited high rates of homelessness.

It was originally intended to recruit individuals in contact with homeless services and those on Local Authority Homeless Lists. These two groups were identified in the 1999 and 2002 assessments of homelessness. As the 2002 assessment was undertaken in Dublin, only homeless services and the four local authorities were included in the most recent assessment unlike the 1999 assessment which was based on ERHA boundaries²². Having a sample of the homeless population not in touch with services was considered important but accessing this group was difficult if local authority lists were outdated, inaccurate or their status questionable. As a result, it was decided to concentrate solely on those in contact with homeless services. Similarly, it was decided to omit those who were solely registered on local authority homeless lists and were not in contact with homeless services in each of the other urban locations; Cork, Limerick and Galway.

2. *To gain information through focus groups from a range of service providers who are increasingly coming into contact with homeless drug using individuals.*

Representatives from a range of drug services and homeless services in Dublin, Cork, Galway and Limerick were targeted and were chosen based on having some degree of operational responsibility for their particular service on a daily basis.

22 The functional area of the Authority includes Dublin, Kildare and Wicklow.

3.3 Involvement of Stakeholders

It was important that any concerns among service providers (e.g. data protection issues, confidentiality of information etc.) were overcome prior to commencement of the study. This was accomplished through the following strategies:

1. An “open forum” session was held in Dublin on February 14th 2003, hosted by the NACD. All homeless service providers from the four different urban locations were invited to attend and were briefed on the background, rationale, research methodology and proposed implementation process.
2. The NACD appointed a Research Advisory Group,²³ comprising of experts and gatekeepers in homeless services. In particular they assisted in finalising the design and testing of the questionnaire, accessing the research population, advising on the recruitment and training of fieldworkers, and commenting on various drafts of reports. Meetings were held regularly between the Research Advisory Group and the Research Department of Merchants Quay Ireland.
3. The support of homeless service providers was undertaken by the following communicative strategies;
 - Presentations outlining the project were made at Homeless Fora²⁴ in Cork, Galway and Limerick in April/May 2003. Furthermore, all homeless services were contacted individually and sent details of the research project.
 - Information and posters outlining the research project were sent to homeless services within the four urban locations. These detailed the range of topics included in the survey as well as emphasising the anonymity and confidentiality of all information provided. The research project was entitled the “Home Truths Research Project” in order to distinguish it from other research projects and to highlight the objectivity of the research as well as targeting those who were members of the homeless population and not using drugs/alcohol. At the consent stage the participants were informed of “who” and “why” the research was being undertaken. Those services who were unable to participate in this research or did not wish to do so were also asked to support the project by disseminating the enclosed information to their clients.
 - A letter outlining the research study and seeking access was sent to all the homeless services which were to be included as potential research sites. This letter requested the participation of the homeless service in question to allow one of the fieldworkers to access and recruit participants for inclusion in the study. Consideration was also given to ensuring that the research project was understood as a study of drug use among the homeless population rather than on homeless drug users specifically. Follow-up phone calls were made to all targeted services in each of the four city locations to ensure access was agreed, to clarify any project details, and to arrange a service contact person for the study. A project presentation was also delivered to various service managers within homeless services.

²³ Members of the Research Advisory Group are outlined within the acknowledgment section of the Report.

²⁴ As a result of the government's *Homelessness – An Integrated Strategy* (2000) a Homeless Forum was established in every county comprising representatives of the health boards, the local authorities and the voluntary organisations involved with services for homeless persons.

3.4 Survey Questionnaire among the Homeless Population

A survey questionnaire was considered the most appropriate way of collecting data on the homeless population as well as obtaining a prevalence figure of drug use among the homeless population.

3.4.1. Questionnaire Content

The survey questionnaire elicited information regarding basic identifiers and personal characteristics, accommodation types, experiences of homelessness, health (physical and mental health), income, drug and alcohol use, risk behaviours, contact with services (homeless, drug and generic) and self-assessment of current needs. The questions were largely close-ended with open-ended questions included within specific sections, such as risk behaviour, assessment of needs and service delivery.

Problematic alcohol use was measured by the employment of the AUDIT (The Alcohol Use Disorders Identification Test Screening Instrument) which is a 10-item screening instrument designed to screen for a range of drinking problems and in particular for hazardous and harmful consumption (Saunders *et al.*, 1993).

The drug component of the questionnaire followed the EMCDDA template of lifetime, current and recent use of various drug classifications. This was complemented by the following drug use scales:

- The Drug Abuse Screening Test (DAST) is used to identify problematic drug use (Gavin *et al.*, 1989). It transpired during some of the pilot interviews that some of the items in the 20-item screening instrument were not appropriate for the homeless population (i.e. questions about employment etc.). In this regard, the shorter 10-point scale was used which was more relevant for this target group.
- The Severity of Dependence Scale (SDS) is a 5-item scale designed to measure the degree of dependence on a variety of drugs, including heroin, cocaine, amphetamines, and methadone (Gossop *et al.*, 1995).

3.4.2 Piloting of Questionnaire

Ten pilot surveys were administered by the researchers during March 2003. The aim of the pilot exercise was to ensure that the questions were clear, unbiased and understood by the participants and that the administration of the survey questionnaire was feasible across a range of homeless services from open-access, low-threshold day-care services to more structured accommodation-based projects. As a result, a broad range of sites was selected for the pilot phase. The time taken to complete the questionnaire averaged between 50-60 minutes and even less time (approximately 30 minutes) with those respondents who did not need to answer the alcohol and drug sections. A number of amendments were made to the questionnaire as a result of the piloting process and following on the recommendations of the Research Advisory Group. General questionnaire changes included structure (clarity regarding interviewer instructions for each section, increase in recording space etc.), rewording of some questions and formatting (creation of open response as opposed to yes/no option).

The changes to the questionnaire following the pilot facilitated high response rates with very little missing data or partially completed questionnaires. Generally, the time the survey took to administer was shorter than had been the case for the pilot exercise. Overall, the average length of time for those who complete all the sections of the questionnaire was 38 minutes (range: 15-105 mins).

3.4.3 Recruitment and Training of Fieldworkers

In view of the sensitive nature of the research project, and to ensure confidentiality, nine fieldworkers were recruited who were not directly involved in the provision of homeless services. Nevertheless it was necessary that they had a good knowledge and understanding of issues relating to homelessness and had experience with working with the target group. Furthermore, their ability to administer the interviews in a sensitive and non-judgmental manner was also taken into consideration.

The fieldworkers participated in a training programme to ensure that they were familiar with, and were well equipped, to undertake the data collection process. The training was delivered by Merchants Quay Ireland's Research Department over one day in May 2003 with inputs from key experts in the area. The training programme outlined the aims and objectives of the study, concepts and background information on drug use and homelessness in Ireland and research training specific to the study (access and negotiation, administration of survey questionnaire, interview skills, role plays, handling problematic situations and possible questions by interviewees, boundaries and limitations of fieldworker involvement, ethical and confidentiality issues).

3.4.4 Research Sites

Research has indicated that the prevalence of drug use can vary according to the setting where the information is collected for example, food centres, day programmes, emergency accommodation, etc. Therefore, the inclusion of a multi-site research project consisting of a broad spectrum of open access and more specialised services was therefore a prerequisite for this study.

No drug services in any of these locations were targeted for the recruitment of members from the homeless population. It was felt that the employment of drug services as typical sites of recruitment would have biased the nature and extent of drug use among this population group. Treatment centres offer access to those whose drug use has reached problematic levels. Needle exchange programmes are also services who are frequented by those prepared to be identified as injecting drug users. Recruiting from drug services would therefore have introduced an obvious bias into the study by neglecting those who may use in an experimental/recreational fashion or those who are problematic and do not access mainstream drug treatment agencies.

3.4.5 Access

The research team worked closely with the Research Advisory Group and their key contacts to ensure that optimal access to the research population was obtained. Overall, there was a high level of support from homeless services and very few declined to facilitate the research²⁵. When access to a service was granted, a member of staff was nominated as the key contact person or 'gatekeeper' and this person facilitated the fieldworker and arranged a room to carry out the surveys. The majority of interviews (90%) were undertaken by the fieldworkers on such sites. Of those which were undertaken elsewhere, 42% were administered within a park setting, 23% in a café, 19% on the street and the remaining 16% in hostels of which the individual was not a resident. In total, individuals were recruited from 50 sites across the four different locations²⁶.

²⁵ Five homeless services who were targeted for the research, all located in Dublin, declined to participate in the research study. These included; 2 hostels catering for single homeless men, 1 female hostel, a day centre for homeless men, women and children, and the remaining refusal was from a specialist homeless service. It is also important to note that clients accessing these services were targeted in other services.

²⁶ This does not represent the total number of sites accessed. Not all sites accessed had homeless individuals to match the sampling frame.

3.4.6 Fieldwork

The data collection process was staggered across different services i.e. participants were initially recruited from hostels, then food centres, then drop-in/street-outreach services, then day/specialised homeless services and lastly information and advice services. Sites were ascribed to each fieldworker at different stages during the research and the fieldworker informed the Research Team when they felt their site was saturated (i.e. if no potential individuals remained for recruitment). Individuals were recruited from sites in accordance with the overall sampling strategy. The numbers recruited from the different sites were not reflective of the site size. Therefore, no claim is made regarding how representative the sample is from each site. Most surveys were administered upon recruitment given the chaotic lifestyle of the population group. Arranging interviews by appointment proved difficult and was the least favoured option employed.

3.4.7 Sampling Frame

Gaining a probability sample of the homeless population is problematic, as it is a mobile, transient group and there is no definitive way of knowing the total number of the population. Therefore quota sampling was used, which is a 'common non-probability technique aimed at producing representative samples without random selection of cases [...] The quotas are organised so that in terms of the quota characteristics the final sample will be representative' (De Vaus, 1996: 78). The quotas for the Dublin sample were developed from the ESRI/Homeless Agency count and refer only to those in contact with homeless services and comprise of 3 variables: gender, age and primary accommodation type (defined by 4 nights or more over the week previous to interview). Age categories included less than 24 years; 25 – 34 years; 35 – 44 years; and 45+ years. Main accommodation categories were rough sleeping, hostel, B&Bs, relatives and friends and other^{27,28}. Given the problems that exist with the methodology in obtaining the original sampling frame,²⁹ it can only be used as a guide for the composition of the homeless population and cannot be argued that it is totally representative.

In the other urban locations (Cork, Galway and Limerick) quota sampling was also employed. However, unlike Dublin, assessments have not been formally carried out on those in contact with homeless services in these locations. Therefore a breakdown of service contact by gender and age was not feasible. However quotas were developed broadly based on one variable (accommodation type) using data from local authority assessments of homelessness.

3.4.8 Monitoring Sample

Each person interviewed was given a unique identifier (initials, gender, date of birth) to avoid being surveyed more than once. A client ID spreadsheet was also provided to all Dublin fieldworkers at least once a week and also disseminated to the fieldworkers outside Dublin. The data collection commenced on June 9th 2003 and finished on October 31st 2003. During this period 355 individuals were interviewed, 247 in Dublin and 108 outside Dublin.

27 "Other" includes accommodation such as; shed, van, squat etc.

28 While the ESRI/HA assessment of homelessness (2002) did count those within transitional housing it did not include this group within their analysis. As the sampling frame for the Dublin Area is based on the ESRI/HA Assessment, it was therefore deemed inappropriate to include transitional housing in the sampling frame.

29 Corr (2003c) highlighted that the count may be an underestimation as it is a point-in-time count, it ignores the hidden homeless, the information may not always be reliable as it depends on accurate returns from local authorities, health boards and voluntary service providers and the organisations who did not respond to the survey are not documented.

3.5 Focus Groups with Service Providers

The second part of the data collection process involved obtaining qualitative information from a range of service providers in Dublin, Cork, Galway and Limerick working in the area of drug use and/or homelessness. Focus groups were deemed the most appropriate way to collect data as they add useful information to large-scale surveys (Krueger, 1994) as well as being 'ideal for exploring people's experiences, opinions, wishes and concerns' (Kitzinger and Barbour, 1999: 5).

3.5.1 Interview Schedule

The interview schedule for the focus groups consisted of four main sections: background information on organisations, service users' characteristics and circumstances, policies, procedures and examples of good practice and finally, strengths and weaknesses in service provision for homeless drug users.

3.5.2 Sample

During July and August 2003, 14 focus groups were carried out with a purposive sample of 64 homeless and drug service providers. Eight focus groups were undertaken within Dublin and two focus groups were undertaken in each of the other cities. Interviewees covered all sectors of drug and homeless services. Drug services included outreach services, needle exchanges, methadone maintenance programmes, residential programmes, therapeutic communities and rehabilitation programmes. Homeless services included accommodation services, day centres, food services, aftercare services and resettlement services. Krueger (1994: 77) advises that focus groups are more successful when they are homogeneous 'but with sufficient variation among participants to allow for contrasting opinions'. In this research homogeneity was sought and each focus group represented a different aspect of service provision (e.g. open-access services, accommodation services, settlement services, services for under-18s, low-threshold services, prescribing services, drug free services etc.). The focus groups were co-ordinated and facilitated by the Research Officers at Merchants Quay Ireland. Each were attended, on average, by five organisations and lasted approximately an-hour-and-a-half to two hours.

3.6 Ethical Issues

In order that the research was carried out both ethically and appropriately and conformed with the research ethics recommended by the funding body, several safeguards were implemented. When finalising the questionnaire particular care was given to the language of questions to avoid accusatory questions. Furthermore, the fieldworkers were encouraged to carry out the interviews in a sensitive manner. Research participants were not identified or exposed as drug users as the project targeted all members of the homeless population. This method promoted the acceptability of the research project among the homeless population. Researching the issue of drug use among the homeless population can be highly sensitive for some interviewees as they could fear potential repercussions on their present or future accommodation needs. Anonymity and confidentiality of all information provided was ensured and all interviewees signed a consent form prior to participation in the study. Participants were offered 15 euro in cash on completion of the questionnaire in order to show that the researchers valued the time they contributed to the research. Similarly, confidentiality was assured to *all* participants in the focus groups so the names and details, or any other issue that might identify organisations were omitted.

The issue of safety of the fieldworkers was also addressed. As part of the training, the fieldworkers were briefed to undertake interviews in service-based areas or other public areas and they were all provided with mobile phones. Moreover, there was a daily limit on the amount of payments each fieldworker had in their possession.

3.7 Data Management

3.7.1 Data Quality Control

In order to exercise control regarding the number of survey questionnaires being administered, only 10 survey questionnaires were given to a fieldworker at any one time. Furthermore, during the initial data collection period, all questionnaires returned by the fieldworkers were checked for any data collection errors or inconsistencies by a member of the research team. Following this period, a proportion of the questionnaires was double-checked by the lead researcher at regular intervals.

3.7.2 Data Protection

Questionnaires and consent forms were stored securely. Information was entered onto a password protected computer, which hindered unauthorised persons access to the research databases.

3.7.3 Data Preparation

Prior to data entry, questionnaires were checked to determine whether they were valid for inclusion in the data collection process. Non-valid questionnaires were removed from the data collection. A code book was developed providing coding instructions for each of the questions included on the survey questionnaire. A response sheet was completed for each questionnaire in accordance with the coding instructions. Missing responses were coded accordingly and the results presented are adjusted for missing data. Open-ended questions were entered into a word document and coded subsequently.

3.8 Data Analysis

The quantitative data from the survey was entered into SPSS for Windows. Analysis of quantitative data was undertaken by applying the appropriate statistical tests within and across different cohorts of the sample, as well as among the total sample.

All focus groups were tape-recorded and fully transcribed. The focus groups generated a great deal of qualitative data which were analysed in a systematic and thorough manner. The whole data set was used in the analysis and coded into relevant themes and patterns using Nud*st 6, as according to Silverman (2000: 186 – 187) 'computer-assisted recording and analysis of data means that one could be more confident that the patterns reported actually existed throughout the data rather than in favourable examples'. The questions in the interview guide acted as the analytical framework although these initial questions were developed and refined in light of new and emerging ideas. Numbers and percentages were not used in the reporting of the focus group data as this can 'sometimes convey the impression that results can be projected to a population and this is not within the capabilities of qualitative research procedures' (Krueger, 1994: 154 – 155). Quotes used in the analysis were chosen to represent typical or common responses. However any variations or negative cases are also described and explained. This is deemed the most systematic and reliable way of treating qualitative data as the findings become more fully 'explored, explained and evidenced' (Dixon, 2004: 19).

3.9 Summary

This chapter has presented an overview of the research process employed to achieve the study aims and objectives. Both qualitative and quantitative methodologies were undertaken as data collection methods. A questionnaire was used to survey 355 homeless persons in Dublin, Cork, Galway and Limerick. This methodology was most appropriate and worked very well with the large numbers recruited. Moreover, the survey combined closed and open-ended questions with various standardised scales to allow different measurements of drug use. The quantitative data collection activities were undertaken by 9 fieldworkers in the period from June to August 2003. Fieldworkers had prior experience of working with the target group although were not currently involved in the provision of homeless services. This positively improved the ease with which the data collection was undertaken. Due to varying data collection methods of those in contact with homeless services in the four city locations, different quota sampling types were used among the Dublin homeless sample and those outside of Dublin.

Fourteen themed focus groups were undertaken with 64 drugs and homeless service providers during July and August 2003. All focus groups were tape-recorded and fully transcribed and coded into relevant themes and patterns. Measures were also taken to ensure that ethical issues were adhered to during the data collection period, in particular confidentiality and anonymity.

Chapter Four

Research Population Profile and Characteristics

4.1 Introduction

This chapter presents an overview of the profile and characteristics of the homeless study population (n=355). Information conveyed includes demographic details, current accommodation, experiences of homelessness, education, employment and legal status. As stated in Chapter Three of the Report, this is a research study of drug use among the homeless population rather than merely of the drug using homeless population. Therefore the data presented throughout this Chapter refers to information collected from all members of the general homeless population irrespective of whether they engage in drug-using behaviour.

4.2 Population Sample

Of the 355 study participants, a total of 247 homeless persons in Dublin were sampled in accordance with the ESRI/Homeless Agency sampling frame provided. This was based on the distribution of homeless persons who accessed services according to gender, age and main type of accommodation in 2002. The remaining participants (n=108) were recruited in Cork, Galway and Limerick using purposive quota sampling techniques. In this regard, demographics of the research population (i.e. gender, age and accommodation type) are not strictly comparable.

Table 4.1 demonstrates the gender of the respondents in each of the four city locations; Dublin, Cork, Limerick and Galway³⁰.

Table 4.1 Gender by Location

Gender	Total Study Population		City Locations							
	(n=355)		Dublin (n=247)		Cork (n=36)		Limerick (n=36)		Galway (n=36)	
	%	n	%	n	%	n	%	n	%	n
Male	69	[244]	71	[175]	58	[21]	72	[26]	61	[22]
Female	31	[111]	29	[72]	42	[15]	28	[10]	39	[14]

³⁰ As illustrated in Chapter Three, gender differences across locations can be largely explained by differing sampling strategies employed.

Table 4.2 demonstrates the age profile of respondents³¹.

Table 4.2 Age by Location

Age	Total Study Population		City Locations							
	(n=355)		Dublin (n=247)		Cork (n=36)		Limerick (n=36)		Galway (n=36)	
	%	n	%	n	%	n	%	n	%	n
< 20 yrs	7	[23]	6	[16]	11	[4]	6	[2]	3	[1]
20-24 yrs	22	[78]	24	[59]	25	[9]	17	[6]	11	[4]
25-29 yrs	13	[47]	13	[32]	8	[3]	14	[5]	19	[7]
30-34 yrs	13	[46]	15	[36]	11	[4]	11	[4]	6	[2]
35-44 yrs	19	[68]	19	[46]	22.5	[8]	19	[7]	19	[7]
45+ yrs	26	[93]	23	[58]	22.5	[8]	33	[12]	42	[15]
Mean Age	35.26 yrs		34.30 yrs		34.28 yrs		37.25 yrs		40.83 yrs	

As illustrated in Table 4.3, although not significant, male respondents were more likely than female respondents to report staying in a hostel (52% v 44%). Over a third of the total female study population reported staying in a B&B (37%). Males were more likely to report rough sleeping than their female counterparts, with a fifth (n=48; 20%) of the male study population reporting this accommodation type in comparison to only 7% (n=8) of the female group.³³

Table 4.3 Current Accommodation Type by Gender

Accommodation	Total Study Population (n = 353)		Male Respondents (n = 242)		Female Respondents (n = 111)	
	%	n	%	n	%	n
Hostel	50	(176)	52	(127)	44	(49)
B&B	19	(69)	12	(28)	37	(41)
Sleeping Rough	16	(56)	20	(48)	7	(8)
Other	10	(34)	10	(24)	9	(10)
Friends/Relatives	3	(12)	4	(10)	2	(2)
Squat	2	(6)	2	(5)	1	(1)
Missing Observations		[2]		[2]		[-]

31 As illustrated in Chapter Three, age differences across locations can be largely explained by differing sampling strategies employed.

32 As illustrated in Chapter Three, accommodation types across locations can be largely explained by differing sampling strategies employed. For the Dublin homeless population this is living in either a hostel/shelter, B&B, squat (e.g derelict buildings etc.), staying with friends and relatives (i.e. insecure, temporary accommodation) or sleeping rough. For the purpose of target locations outside of Dublin (i.e Cork, Galway and Limerick), a broader definition was employed to include transitional housing or long term supported housing (See Research Methodology – Chapter Three).

33 Gender differences across locations can be largely explained by differing sampling strategies employed.

Table 4.4 demonstrates the current accommodation type of the respondents in each of the four city locations³².

Table 4.4 Current Accommodation Type by Location

Accommodation	Total Study Population		City Locations							
	(n=353)		Dublin (n=245)		Cork (n=36)		Limerick (n=36)		Galway (n=36)	
	%	n	%	n	%	n	%	n	%	n
Hostel	50	[176]	45	[109]	64	[23]	83	[30]	39	[14]
B&B	19	[69]	26	[64]	3	[1]	3	[1]	11	[4]
Sleeping Rough	16	[56]	19	[47]	19	[7]	-	-	6	[2]
Other	10	[34]	4	[9]	11	[4]	14	[5]	44	[16]
Friends/Relatives	3	[12]	4	[10]	3	[1]	-	-	-	-
Squat	2	[6]	2	[6]	-	-	-	-	-	-
Missing Observations		[2]		[2]		[-]		[-]		[-]

“Other” current accommodation refers to transitional housing (17), car (2), detox centre (2), tent (2), shed (5), long-term resettlement (4), boat (1), recovery house (1). The numbers for transitional accommodation under Table 4.3 above refer to current accommodation of members of the study population outside of Dublin as this accommodation type was not collected within the Dublin sample.

Analysis revealed that there were age differences across various accommodation types. Individuals who reported that they were staying in a hostel were older (mean age=37.1 years) than those who reported staying in a B&B (mean age=30.1 years), sleeping rough (mean age=33.3 years), squatting (mean age = 30.8 years) or staying with friends or relatives (mean age=27.4 years)³⁴.

Respondents were also asked with whom they shared their current accommodation. This question was primarily intended to ascertain whether they had any responsibility for the accommodation needs of dependent children. Over three-quarters of the sample reported being on their own (n=261; 78%), 11% shared with a partner (n=36), 5% reported living in accommodation alone with children (n=18), another 5% reporting living with a partner and children (n=16) and the remaining individuals reported sharing with friends (n=3; 1%)³⁶. Those who either lived alone with children, or with partner and children, were asked to report the number of children under 18 years. Sixty-eight percent (n=19) of those who reported sharing their accommodation with children had 1 dependent child, 14% (n=4) had 2 dependent children, 11% (n=3) had 3 dependent children and the remaining respondents (7%; n=2) had 4 and 5 dependent children³⁵.

4.2.1 Length of Time in Current Accommodation

All respondents were asked how long they have been in their current homeless accommodation. This does not necessarily relate to the length of time the clients have been homeless. Nearly two-thirds of the respondents (n=224; 64%) were in their current accommodation for periods of less than six months. More specifically, 15% (n=52) of the total study population were in their current accommodation for “a few days”, while over a quarter (n=95; 27%) reported length of time as “a few

³⁴ Age differences across locations can be largely explained by differing sampling strategies employed.

³⁵ This does not relate to actual number of children per respondent. Respondents were not asked if they had any children as it was considered particularly sensitive if there was no child-care responsibility involved.

³⁶ All percentages cited throughout the report are based on valid percentages, adjusted for missing data.

weeks", and over a fifth (n=77; 22%) for "a few months". This illustrates the high mobility patterns of the homeless population within and across homeless accommodation types. However, 23% (n=81) reported being in their current accommodation in excess of one year. Twenty-six percent (n=63) of male respondents reported such, in comparison to only 16% (n=18) of female respondents.

In terms of length of time in current accommodation by homeless accommodation type, nearly half (n=26; 47%) of those who reported sleeping rough at the time of interview had been doing so in excess of the last six months in contrast to less than a third of hostel dwellers (n=56; 32%) and just over a fifth of B&B occupants (n=15; 22%).

4.3 Population Profile

4.3.1 Nationality and Ethnic Origin

The majority of the total study population (n=315; 89%) was Irish with the remaining 11% (n=40) largely comprising of individuals from Northern Ireland, England, and Scotland. However in Cork, only three quarters (75%) of the homeless population were from Ireland. In terms of ethnicity, 95% (n=337) of the total study population were from the majority white population, 4% (n=15) were members of the traveller community, two individuals were of a black or mixed ethnic group and the remaining response was coded as missing.

4.3.2 Last Permanent Address

Respondents were also asked to report their last known permanent address. Within the Dublin homeless sample, the largest proportion of individuals reported their last permanent address as being in the South Dublin suburbs (D.22 & D.24; 17%), the North Inner City (D.1 & D.7; 14%), and the South Inner City (D.2 & D.8; 14%). Seven percent (n=16) of the respondents reported their last known address as being in the UK.

Outside of Dublin, the majority of respondents (Cork-69%; Limerick-74%; Galway-60%) reported their last permanent address as being the city within which the interviews were undertaken. However, there was also indications of various mobility patterns across different locations. For example, within the Galway sample, 40% of the respondents reported their last permanent address as being outside of Galway.

4.3.3 Registration on a Local Authority Housing List

Over two-thirds of the total study population (n=240; 68%) reported being currently registered on a Local Authority Housing List. Almost one-third of the respondents were not registered (n=113; 32%). This information was obtained through self-reported data using the survey questionnaire as illustrated in the previous chapter, and as such, was not verified with the local authorities in question. However, what is not possible to ascertain is what proportion of these individuals, who are not registered on a local authority housing list, are eligible for social housing. Any prior evictions can reduce the potential likelihood for an individual to be rehoused by the local authority.

Over two-thirds of hostel dwellers (n=75; 69%) and rough sleepers (n=31; 66%) in the Dublin sample said they were registered with the local authority. The vast majority (n=59; 92%) of those staying in B&B accommodation in Dublin were registered with the local authority. Of those registered within the Dublin sample, the vast majority (n=161; 89%) reported being registered with Dublin City Council,

followed by South Dublin County Council (n=10; 6%) and Dun Laoghaire/Rathdown (n=4; 2%). The remaining three percent (n=5) comprised of Fingal, Wicklow and Galway County Council, with an individual reporting both Dublin City Council and South Dublin County Council and one on the Traveller Housing Waiting List. The high percentage of those registered with Dublin City Council may be indicative of the large homeless population group located in the city centre. Outside Dublin, none of the respondents who reported being on a local authority housing list were registered in Dublin.

The average number of months since entry onto the housing list was 28 months (2.3 years) for the Dublin sample (median=17 months; range=1-168 months)³⁷ in comparison to 34.2 months (2.9 years) for the homeless population outside of Dublin (median= 12 months; range=1-180 months). In terms of number of weeks since last contact with the Local Authority Housing Department, the mean for the Dublin sample was 13 weeks (median= 4 weeks; range= 1-156 weeks)³⁸ in comparison to 25 weeks for the homeless population outside of Dublin (median= 8 weeks; range= 1-156 weeks).

4.3.4 Local Authority Housing and Anti-Social Behaviour

Individuals were also asked if they had ever lived in local authority accommodation, and if they were ever asked to leave due to anti-social behaviour. Results illustrate that less than half of the respondents (n=142; 41%) reported having ever lived in local authority accommodation³⁹. Of those that lived in local authority accommodation, nearly one-in-five reported having been asked to leave due to anti-social behaviour (n=27; 19%). Over one-in-four of those evicted cited drug use as the reason for their eviction. Overall, a total of two-fifths (n=11) cited either drug use or drug dealing as the primary reason for their eviction, which represents 3% of the study population.

4.4 History of Homelessness

4.4.1 Length of Time Currently Homeless

All respondents were asked how long they have been currently homeless. Almost one-in-five of respondents reported their current episode of homelessness as being in excess of five years (n=61; 18%) with one respondent stating that their current episode of homelessness had lasted for more than 38 years. A third of the total study population (n=112; 33%) reported being homeless for a period of less than six months. Although not significant, women on average reported a slightly shorter duration of being currently homeless (mean=118 weeks) than was the case for their male counterparts (mean=133 weeks). In terms of homeless accommodation, those staying in hostels reported a higher mean length of time homeless than either those staying in B&B accommodation or those sleeping rough (146.7 weeks v 112.5 weeks and 113.40 weeks respectively).

Mean length of time currently homeless was substantially shorter for those outside Dublin (mean= 73.5 weeks; SD= 129.79; range 1-780 wks) than for the Dublin homeless population (mean= 153.82 weeks; SD= 229.03; range 1-1976 weeks)⁴⁰. More specifically, almost three-quarters of the study population in Cork (n=25; 71%) and Limerick (n=26; 72%) and over a half in Galway (n=19; 53%) were currently homeless for less than twelve months, in comparison to 40% (n=94) within the Dublin sample.

37 Outliers were removed from the Dublin sample for appropriate calculation of the mean length of time on housing list. Original range was 1-300 months.

38 Outliers were removed from the Dublin sample for appropriate calculation of the mean length of time since last contact with Local Authority housing department. Original range was 1-364 weeks.

39 The question asked did not specify whether this was as a member of a household living in local authority housing or under their own tenancy.

40 This can largely be explained by the different accommodation types included within the sampling strategies employed across locations.

4.4.2 Experience of Homelessness

All respondents were asked whether their current experience of being homeless was their first. Over half of the sample group (n=211; 59%) reported prior experiences of homelessness. This remained largely the same for the Dublin sample with 56% (n=138) of respondents having had prior experience of homelessness. Cork and Galway samples displayed the highest level of prior homelessness (75% and 72% respectively)⁴¹.

Analysis revealed that although not 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-two percent (n=69) of female respondents reported this compared with 58% (n=142) of male respondents.

Respondents who reported that they had prior experience of homelessness were also asked how many times they had been homeless and the longest period of time they had spent homeless. A third of respondents (n=65; 33%) reported that their longest period homeless was less than one year. A further 18% (n=35) reported that their longest period out of home was between 1-2 years. Five percent (n=9) of the sample reported that their longest time out of home was in excess of ten years.⁴²

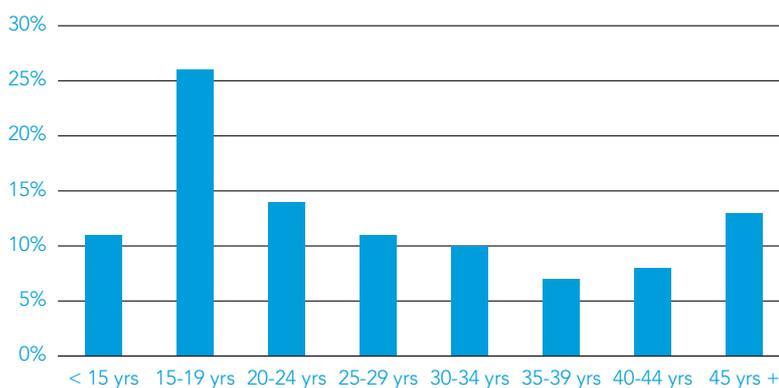
The mean length of time homeless for those who had prior experience was 130.48 months or 10.9 years (SD 147.331; range 1-780 months). Analysis revealed that although not significant, female clients on average had experienced longer periods of homelessness than their male counterparts. Women reported an average of 117.3 months (9.8 years) of homelessness, while their male counterparts reported 137.6 months (11.5 years) of homelessness.

Those for whom this was not their first experience of homelessness reported an average of 7 times homeless (range: 1-60 times). Twelve respondents also reported that they were homeless on "many occasions", or "too many to remember" and as such their response was coded as "countless".

4.4.3 Age First Homeless

Figure 4.1 illustrates the age first homeless of the total study population. Over a third of respondents reported the age of first becoming homeless as 19 years or less (n=132; 38%) with 11% (n = 40) reporting the age of first becoming homeless as less than 15 years⁴³. Sixty-four per cent (n=70) of the female respondents reported first becoming homeless as less than 25 years in comparison to 47% (n=112) of the male respondents.⁴⁴

Figure 4.1 Age First Became Homeless of Total Study Population



41 The higher levels of previous homelessness in Cork and Galway could be as a result of the sampling strategy employed as the age distribution of respondents in these locations are older.

42 All percentages cited throughout the report are based on valid percentages, adjusted for missing data.

43 The figure reporting age first homeless as 15 years or less refers both to those unaccompanied and also those who were homeless with their families.

44 All percentages cited throughout the report are based on valid percentages, adjusted for missing data.

The mean age respondents first became homeless was 27.4 years⁴⁵. Female respondents reported a younger age of first becoming homeless than their male counterparts. Analysis revealed that women were first homeless at a significantly younger age than male respondents (t-test =3.15; df=344; p<0.05). Female respondents were on average 24 years-of-age when first homeless, while the male respondents were on average 29 years-of-age. Further analysis by current homeless accommodation type revealed that the mean age of first becoming homeless was higher for those staying in hostels (29.4 years) than for any other group. This is in comparison to 23.3 years for B&B occupants and for those staying in squat; 24.5 years for the rough sleeping sample; and 22.7 years for those residing with friends and relatives.

Outside Dublin, the mean age of first becoming homeless was 29.7 years in comparison to 26.4 years for the Dublin homeless population⁴⁶. Table 4.5 below illustrates the age breakdown of first becoming homeless by city location. As conveyed, Cork exhibits the lowest mean age of 25.9 years followed by Dublin with a mean age of 26.4 years.

Table 4.5 Age First Became Homeless

Location	Age First Became Homeless					
	N	Mean Age	Median Age	Mode Age	SD	Age Range
Dublin	242	26.4	22	17	12.72	11-79
Cork	33	25.9	21	12*	12.9	11-58
Limerick	36	31.8	31	21*	13.22	12-60
Galway	35	31.1	27	13*	13.24	13-64
Total Population	346	27.4	24	17	13	11-79

*Multiple modes exist. The smallest value is shown.

4.4.4 Reasons for Homelessness

As the factors causing homelessness are often complex and intertwined, respondents were asked to report both their primary and any secondary contributory reasons for becoming homeless.

Primary Reason: Table 4.6 illustrates the main reason triggering respondents' first episode of homelessness. Nearly a quarter (n=84; 24%) of the total study population reported family conflict as the primary reason for first becoming homeless. Drug use was cited as the second most common reason for becoming homeless. Nineteen percent (n=67) of the respondents cited personal drug use while 13% reported personal alcohol use (n=44). Female respondents were proportionally more likely to report personal drug use as a primary factor, in comparison to their male counterparts (24% v 17%) while male respondents were proportionally more likely to report personal alcohol use (17% v 4%).

45 First homeless included ages 2, 7, 8 and 9 as part of a family. These were removed for the purpose of calculating means in order to prevent skewing of data.

46 Differences in mean age first homeless across locations can be largely explained by differing sampling strategies employed.

Table 4.6 Main Reason for First Becoming Homeless

Main Reason	Total Study Population		City Locations							
	(n=350)		Dublin (n=243)		Cork (n=35)		Limerick (n=36)		Galway (n=36)	
	%	n	%	n	%	n	%	n	%	n
Family Conflict	24	[84]	27	[65]	27	[9]	19	[7]	8	[3]
Drug Use-Personal	19	[67]	23	[55]	20	[7]	6	[2]	8	[3]
Alcohol Use-Personal	13	[44]	11	[26]	11	[4]	22	[8]	17	[6]
Relationship Breakdown	8	[30]	7	[18]	11	[4]	3	[1]	19	[7]
Money Problems	5	[19]	5	[12]	-	-	14	[5]	6	[2]
Domestic Violence	5	[16]	2	[6]	11	[4]	17	[6]	-	-
Mental Illness-Personal	3	[10]	1	[3]	6	[2]	8	[3]	6	[2]
Other ⁴⁷	23	[80]	24	[58]	14	[5]	11	[4]	36	[13]
Missing Observations		[5]		[4]		[1]		[-]		[-]

Across city locations, over one-fifth of the respondents in Dublin and Cork reported personal drug use as the primary reason. However, as illustrated in Table 4.6, figures were substantially lower in Limerick and Galway. Alternatively personal alcohol use as a primary reason for becoming homeless was higher in Limerick (22%) and Galway (17%) in comparison to 11% in both Dublin and Cork.

Secondary Reasons: The questionnaire was designed to allow respondents provide more than one secondary reason for becoming homeless. Similar to main reason for homelessness, family conflict was reported as the highest secondary reason for first becoming homeless (12%; n=44). Unlike the main reason for first becoming homeless, a higher number of individuals reported personal alcohol use than personal drug use as a secondary reason. One-in-ten of the respondents (n=36; 10%) reported personal alcohol use and 9% reported drug use (n=33). Although not significant, male respondents were more likely to cite personal drug use as a secondary factor than their female counterparts (10% v 7%).

47 Family member/spouse died (n=9), evicted from local authority (n=9), told to go by landlord (n=6), asked to leave by family (n=5), physical/sexual abuse (n=5), evicted from private rented accommodation (n=4), unfit accommodation (n=4), leaving institution/prison (n=3), alcohol use-family (n=2), physical health problems (n=2), lost job (n=2), early school leaving (n=2), personal choice (n=2), gambling (n=2), intimidation (n=2), previous accommodation sold (n=2), returned from UK (n=1), lost LA accommodation – went to care for mother (n=1), violence from school teachers (n=1), house burnt down (n=1), lonely living alone (n=1), pregnancy (n=1), sold house/lost money (n=1), threatened and had to move (n=1), alcohol use of other tenant (n=1), ADHD problems at home (n=1), government system (n=1), caused problems in residential setting and was asked to leave (n=1), expelled from priesthood (n=1), trouble with police (n=1), lost passport in London on way to Amsterdam (n=1), pressure from local community (n=1), evicted due to anti-social behaviour (n=1), court order/notice to quit (n=1), became homeless as a result of drug use of a family member (n=1).

Table 4.7 Secondary Reasons for First Becoming Homeless

Main Reason	Total Study Population		City Locations							
	%	n	Dublin		Cork		Limerick		Galway	
			%	n	%	n	%	n	%	n
Family Conflict	12	[44]	13	[32]	17	[6]	8	[3]	8	[3]
Alcohol Use-Personal	10	[36]	7	[16]	22	[8]	17	[6]	17	[6]
Drug Use-Personal	9	[33]	9	[21]	11	[4]	8	[3]	14	[5]
Relationship Breakdown	8	[29]	9	[21]	14	[5]	-	-	8	[3]
Money Problems	6	[22]	5	[12]	6	[2]	6	[2]	17	[6]
Alcohol Use-Family	6	[20]	5	[13]	8	[3]	6	[2]	6	[2]
Asked to Leave by Family	4	[15]	6	[15]	-	-	-	-	-	-
Physical/Sexual Abuse	4	[15]	6	[14]	3	[1]	-	-	-	-
Other ⁴⁸	22	[80]	20	[49]	22	[8]	41	[15]	22	[8]

**Multiple responses were allowed*

Remaining Homeless: All individuals were also asked to state the primary reason for remaining homeless. As illustrated in Table 4.7, lack of access to local authority accommodation was cited as the most frequent factor in respondents remaining homeless (n=86; 25%)⁴⁹. Just over one-in-ten of the study population reported continuing drug use (n=39; 11%) or money problems (n=39; 11%) as their primary reason for remaining homeless. Continuing alcohol use was less frequently reported by respondents (n=25; 7%).

48 Physical health problems (n=7), domestic violence (n=7), mental illness- personal (n=7), drug use-family (n=5), unfit accommodation (n=5), leaving institution-prison (n=4), parent(s) died (n=4), job finished (n=4), told to go by landlord (n=3), lost job (n=3), evicted from private rented (n=3), gambling (n=2), personal choice (n=2), home lost in fire (n=2), lost job due to disability (n=2), mixing with wrong people/crowd (n=2), alcohol use among housemates (n=2), evicted from local authority (n=2), barring order (n=1), sibling died/emotional breakdown (n=1), not considered eligible for LA housing (n=1), criminal activities (n=1), lack of education/literacy (n=1), chose to leave community due to the availability of drugs there (n=1), went with boyfriend who was forced to leave home (n=1), disowned by family because of sexuality (n=1), criminal conviction (n=1), lost LA house (n=1), death of a friend (n=1), evicted due to anti-social behaviour (n=1), court order/notice to quit (n=1), mental illness-family (n=1).

49 Due to the coding schedule employed it is not possible to ascertain the reasons for lack of access to local authority housing.

Table 4.8 Main Reason for Remaining Homeless

Main Reason	Total Study Population (n=343)		City Locations							
	%	n	Dublin (n=238)		Cork (n=33)		Limerick (n=36)		Galway (n=36)	
Cannot Access Housing- L. Authority	25	[86]	31	[74]	12	[4]	8	[3]	14	[5]
Continuing Drug Use	11	[39]	15	[35]	6	[2]	3	[1]	3	[1]
Money Problems	11	[39]	10	[23]	-	-	25	[9]	19	[7]
Cannot Access Housing-Private Rented	11	[37]	7	[17]	27.5	[9]	14	[5]	17	[6]
Family Conflict	9	[31]	11	[26]	6	[2]	8	[3]	-	-
Continuing Alcohol Use	7	[25]	5	[13]	18	[6]	3	[1]	14	[5]
Personal Choice	5	[16]	3	[8]	3	[1]	6	[2]	14	[5]
Other ⁵⁰	21	[70]	18	[42]	27.5	[9]	33	[12]	19	[7]
Missing Observations		[12]		[9]		[3]		[-]		[-]

4.5 Education and Employment

In terms of education, a quarter of the total study population (n=88; 25%) reported that primary education or less was their highest level reached and half reported (n=176; 50%) having reached lower second-level education. Fifteen percent (n=54) reported upper second-level education. Only 6% (n=20) of the overall study population reported having completed higher education. The remaining 4% (n=13) reported 'other' education such as, FÁS courses and apprenticeships. Little variations exist across the city locations.⁵¹

Two-thirds of the total study population (n=233; 66%) were unemployed at the time of interview with 24% (n=83) also reporting being unable to work. The remaining 10% (n=35) reported training courses, childrearing and retirement. This also included 3 individuals who were in employment at the time of interview.

4.6 Sources of Income

All individuals were asked to report the various sources of income. Multiple responses were allowed. Government benefits were cited by the majority of respondents (n=336; 95%), while criminal activities were reported by 15% (n=54) of the total study population. Less than one-in-ten of the respondents reported employment as an income source, whether regular (n=4; 1%) or occasional employment (n=30; 8%). Respondents received the most income from government benefits. Nearly three-quarters of the total study population cited government benefits as their primary source of income (n=263; 78%).

50 No job (n=2), physical disability (n=2), needs caravan as children in care (n=2), emigration (n=2), lack of training (n=1), lack of upbringing (n=1), just moved to Ireland (n=1), can't get a referral (n=1), left hospital directly referred to homeless services (n=1), domestic violence continues (n=1), gambling (n=1), length of time homeless-institutionalised (n=1), others drug/alcohol use (n=1), short term homeless (n=1), ADHD (n=1), no other choice (n=1), lack of ID (n=1), discrimination (n=1), not ready (n=1), waiting on a house (n=1), wants to be rehoused but not in same area (n=1), friend stole from landlord (n=1), had a fight with the landlord (n=1).

51 All percentages cited throughout the report are based on valid percentages, adjusted for missing data.

Ten percent (n=33) reported criminal activities, while 6% (n=20) reported begging. The remaining 6% reported their primary income source as family/friends, regular/occasional employment and various other sources.

4.7 Legal Status

Respondents were asked about their experience of imprisonment. Fifty-five percent (n=193) of the total study population reported having spent some time in prison. Sixty-one percent of the Dublin homeless sample reported having spent time in prison in comparison to 41% of the respondents from outside of Dublin.

Analysis revealed that male respondents were significantly more likely to report having being in prison than their homeless female counterparts ($\chi^2 = 13.97$; $df=1$; $p<0.01$). Sixty-two percent (n=149) of the male respondents reported having spent time in prison in comparison to only 38% (n=44) of the female respondents. Rough sleepers were proportionally more likely to report previous experience of imprisonment than their counterparts staying in hostel or B&B accommodation. Seventy-one percent (n=39) of rough sleepers reported previous imprisonment in comparison to 50% (n=85) of hostel dwellers and 58% (n=40) of B&B occupants.

Two-thirds of the study population (66%) reported currently having no legal issues. Fourteen percent (n=48) of the homeless sample reported being on bail awaiting trial/sentencing and a further 14% reported having outstanding warrants (n=48). "Other" legal status specified refer to; charges waiting (n=5), on remand (n=1), charge in absence (n=1), temporary release (n=1), due in court (n=1).

Table 4.9 Current Legal Status

Legal Status	Total Study Population	
	%	n
No Legal Issues	66	[230]
On Bail Awaiting Trial/Sentencing	14	[48]
Outstanding Warrants	14	[48]
Outstanding Fines	7	[24]
Contact With Probation/Community Services	5	[17]
Other	3	[9]

**Multiple responses were allowed*

4.8 Summary and Conclusions

This chapter has presented an overview of the characteristics of the total study population (n=355). The following are some of the main findings on the research participants –

Socio-Demographic Details:

- **There were twice as many male respondents as female respondents interviewed yielding a gender ratio of 2:1.**

This gender ratio is not surprising given the sampling strategies which were employed. Homeless women, especially single homeless women, are often regarded as “hard to reach” or “hidden” (Jones, 1999). Nevertheless, research studies in other countries have highlighted that there is an increase in the number of women among the homeless population with some commentators supporting the view that women and children have become the fastest growing sector of the homeless population (Smith, 1999). Harvey (1998) has alluded to the *feminisation* of the homeless population.

- **The average age was 35 years. However, over a quarter of the sample was less than 25 years of age. Female respondents were significantly younger than the male counterparts.**

National (Corr, 2003a) and international literature (Warnes, 2003) suggest that the homeless population is getting younger. Literature also supports the finding that within the homeless population, women as a whole are a much younger sub-group (Kemp, 1997).

- **The majority of the total study population (89%) were Irish with the remaining 11% largely comprising of individuals from Northern Ireland, England, and Scotland.**

This is consistent with other studies carried out among Irish homeless populations (Holohan, 1997; Feeney *et al.*, 2000; Corr, 2003a).

- **The majority of respondents identified themselves as single (78%). Only 10% of the study population were living with children, of whom half were living alone with children in their accommodation.**

These findings are consistent with British research which has found that single males, and lone parents to a lesser extent, are most likely to experience homelessness (Burrows, 1997). The reported number of those living with children is lower than other data would indicate despite the sampling strategies employed (gender, accommodation and age).

- **Individuals staying in a hostel were older (mean age=37 yrs) than those who reported sleeping rough (mean age= 33 years), squatting (mean age=31 years), staying in a B&B (mean age= 30 yrs), or staying with friends or relatives (mean age=27 years).**

Research has indicated that single homeless males account for the majority of those who stay in hostels (Crane and Warnes, 2001). This is also consistent with the policy on placement in Dublin. UK research has indicated that among hostel dwellers, a higher proportion are aged 50 and over than under-25 (Warnes *et al.*, 2003). Several factors influence the age structure in general hostels, for e.g. the availability of specialist young people projects, hostels’ admission criteria, resettlement practices and move-on opportunities (Warnes *et al.*, 2003:30).

- **The largest proportion of individuals in the Dublin sample reported their last permanent address as being in the South Dublin suburbs (D.22 & D.24; 17%), the North Inner City (D.1 & D.7; 14%), and the South Inner City (D.2 & D.8; 14%). Seven percent (n=16) of respondents reported their last known address as being in the UK.**

Studies have illustrated that these Dublin communities are also disproportionately affected by drug use (Comiskey, 1998) and are also areas in which local drugs task forces operate. The centralisation of service provision in Dublin could also mean that individuals are more likely to relocate towards these areas. A profile of outreach service users in 2002 by the Dublin Simon

Community reported that a large proportion of new contacts were returning emigrants or immigrants from the UK. Seventeen percent of their contacts were with individuals whose last address was in the UK (Dublin Simon Community, 2003:5).

- **Respondents demonstrated low educational attainment and poor economic status. Only 6% of the overall study population reported having reached higher education and a further minority of the sample were in employment (regular or occasional). The majority of respondents were dependent on government benefits.**

This is comparable with findings from other studies carried out among Irish homeless populations (Feeney *et al.*, 2000, Corr, 2003a). Similar results were found in a review of homeless profiles in Britain (Warnes *et al.*, 2003). Unemployment is persistently seen as a major contributory factor to homelessness (Greve, 1997) as it makes it difficult for homeless people to compete in the housing market (Homeless Agency, 2001).

- **Over half of the total study population reported previous experience of imprisonment. Analysis revealed that male respondents were significantly more likely to report having being in prison than their female counterparts.**

The association between homelessness and crime has been well documented by Hickey (2002). Figures for levels of imprisonment are similar to those cited by other Irish studies undertaken among the homeless population (Feeney *et al.*, 2000; Corr, 2003a). The high male gender distribution also reiterates previous findings (Cleary and Prizeman, 1998; Corr, 2003a). Among the prison population sample, O'Mahoney (1997) found that 7% of the sample were homeless (O'Mahoney, 1997). A higher incidence of homelessness among the prison population has been noted by PACE (2002) which found that 33% of all Irish female prisoners in the Dochas Centre would be homeless upon release and 35% of men reported that they would not have any accommodation following their release (cited in Focus Ireland, 2001).

- **Rough sleepers were proportionally more likely to report previous experience of imprisonment than their counterparts staying in hostel or B&B accommodation. Seventy-one percent of rough sleepers reported previous imprisonment in comparison to 50% of hostel dwellers and 58% of B&B occupants.**

Research from the U.K indicates that around half of the people sleeping rough have been in prison or a young offenders' institution, many of whom also have repeated contact with the police and court system (Crisis UK 1999, cited in Bergin 2000).

Homeless Accommodation:

- **Hostel, B&B, and rough sleeping were the most reported homeless accommodation types. Half of the study population currently resided in hostel accommodation (n=176; 50%). Nineteen percent (n=69) reported current B&B accommodation while 16% (n=56) reported rough sleeping. Although not significant, male respondents were more likely than female respondents to report hostel accommodation and rough sleeping.**

This profile of homeless accommodation and gender distribution of accommodation largely reflects the sampling strategies which were employed. Single homeless males account for the majority of those who stay in hostels (Crane and Warnes, 2001; Feeney *et al.*, 2000) while the majority of those using B&B accommodation in Dublin are women with children (Houghton and Hickey, 2000; Smith *et al.*, 2001).

- **Findings revealed that 64% (n=224) were in their current accommodation for periods of less than 6 months, 13% (n=46) for 6 months to 12 months and 23% (n=81) in excess of one year.**

This indicates high levels of mobility across accommodation services.

- **Over one-in-five of those reporting staying in B&B had done so for more than six months.**

Houghton and Hickey (2000: 22) have commented that the longer the duration of B&B stay the longer the homeless cycle for the household. Furthermore, the prolonged use of B&B accommodation for emergency purposes is reported to have health and social implications (Houghton and Hickey, 2000).

- **Nearly half (47%) of individuals who reported their current accommodation as rough sleeping had done so in excess of the last six months in contrast to less than a third of hostel dwellers (32%) and just over a fifth of B&B occupants (22%).**

There is a lack of direct access accommodation for rough sleepers partly because of the “silt up” of bed spaces whereby existing residents are not moving on to other accommodation (Cox and Lawless, 1999). Individuals are remaining in emergency accommodation longer, thereby making the movement through homelessness slower (Houghton and Hickey, 2000). Older single homeless people who have slept rough for many years have the most intensive support needs of all (Crane and Warnes, 2001).

History of Homelessness:

- **Over a third reported age first homeless as 19 years or less (n=132; 38%) with 11% (n = 40) reporting age first homeless as less than 15 years.**

This is lower than the figure cited by Cleary and Prizeman’s (1998) research, in which 58% of the sample had become homeless by the age of 20 years. A decrease in youth homelessness may be due to the substantial progress which has been made in recent years in terms of ensuring a more co-ordinated and planned approach to tackling youth homelessness. The current national strategy on youth homelessness recognises the links between youth and adult homelessness and the role of preventative measures.

- **Personal drug use (n=67; 19%) was cited as the second most common reason for becoming homeless. Thirteen percent reported personal alcohol use (n=44). Alcohol use as a primary reason for becoming homeless was higher in Limerick and Galway (22% and 17% respectively) in comparison to 11% in both Dublin and Cork.**

Problematic drug and alcohol use is known to be a trigger and a consequence of homelessness. In a study of rough sleepers in London, almost two-thirds of the sample reported drug or alcohol use as one of the main reasons they first became homeless (Fountain and Howes, 2001). Holohan (1997), in a study of homeless people in Dublin, found that drug/alcohol use was the most frequently cited cause of homelessness (24%). Houghton and Hickey (2000) in their study on emergency B&B placement in Dublin, similarly reported drug use as a primary reason among single adults in becoming homeless (21%). Among those regarded as long-term homeless, 16% reported drug-related problems as the principal cause of their homelessness (Houghton and Hickey, 2001). It is important to state that reasons for becoming homeless are not necessarily the “definitive” causes of homelessness as individuals may often report the trigger factor rather than the causal factor (Houghton and Hickey, 2000).

- **In terms of anti-social behaviour, 3% (n=11) of the total study population cited drug use or dealing as the primary reason for their eviction from local authority housing.**

Irish studies have indicated that the use of the Miscellaneous Provisions Act (1997) has led to increased levels of homelessness among particular population groups, such as drug users (Cox and Lawless, 1999; Memery and Kerrins, 2000; Lawless and Cox, 2003). More specifically, concern regarding the indirect use of the Act which provides the local authority with extended powers to refuse to let, to sell and to deny rent allowance to those evicted under anti-social behaviour was seen as likely to result in an increase in homelessness (Memery and Kerrins, 2000).

Experience of Homelessness:

- **Over a half of the total study population (n=211; 59%) reported that the current experience of homelessness was not their first and reported an average of 7 episodes of homelessness. Higher mean lengths of time currently homeless were found among the Dublin sample, the male population and among those staying in hostels.**

The findings show that many individuals have experienced homelessness on a number of different occasions which indicates that they are moving in and out of homelessness. For others, homelessness may represent a single acute episode in a person's life. This figure is substantially higher than the 40% reported by Feeney *et al.* (2000) to have been homeless on more than one occasion but lower than the 67% cited by Corr (2003a).

- **Over a half of the total study population reported length of time currently homeless as being in excess of a year (52%; n=176) with 2.5 years as the mean length of time homeless.**

This is consistent with other Irish studies which have indicated a high level of very long-term homelessness (Holohan, 1997; Houghton and Hickey, 2001; Williams and Gorby, 2002; Corr, 2003a). In a study of the long-term homeless in Dublin, individuals were recorded as currently being homeless for a mean average of over one-and-half-years (mean 84 weeks) (Houghton and Hickey, 2001). This study found a much higher mean of 153.8 weeks for the homeless population.

- **Forty-five percent of rough sleepers (n=24) reported their current length of time homeless as being in excess of one year, of which 19% (n= 10) reported being in excess of five years.**

Bergin (2000) found that the proportion of rough sleepers homeless for more than one year had increased from 62% in 1997 to 65% in 1998 to 68% in 2000. A profile of outreach service users by the Dublin Simon Community in 2002 illustrates that over a third were homeless for 1-5 years (37%) with a significant percentage also reporting length of time homeless as being in excess of 5 years (28%) (Dublin Simon Community, 2003).

Chapter Five

Patterns of Alcohol Use

5.1 Introduction

National and international studies of the homeless population refer to alcohol as the main drug of use among the homeless population. In this regard, the focus of this chapter is to present information on the patterns of alcohol use among those interviewed for this research (n=355). To this end, frequency of consumption, problematic measures of use and service issues are documented herein.

5.2 Frequency of Alcohol Consumption

Table 5.1 illustrates the frequency of alcohol consumption by city location. Overall, almost a third of the study population (30%) reported never consuming alcohol. A limitation of the study was the omission of a question regarding previous experience of having undergone an alcohol detox. This would have provided additional information on those who reported never consuming alcohol. However, one-in-five of the total study population reported consuming alcohol 2-3 times a week with nearly one-in-four reporting alcohol consumption in excess of four times a week. A higher mean age was found among those who reported alcohol use in excess of four times a week (36.8 years) than among any of the other frequency groups (33.8 years, 34.2 years, 35.6 years respectively). The mean age of first alcohol use for the total study population was 15 years and this remained consistent across the city locations (range 4-35 years).

Frequency of alcohol consumption differed among the city locations. Only 11% of the Galway sample reported drinking more than four times a week, followed by one fifth (20%) of the Dublin sample and over a third (37%) in Cork. The Limerick sample displayed the highest frequency rates of alcohol use. The proportion of people reporting drinking alcohol more than 4 times a week at 46% was 4 times higher in Limerick than in Galway and more than twice that of Dublin.

Table 5.1 Frequency of Alcohol Consumption by Location

Alcohol Use	Total Study Population (n=352)		City Locations							
	%	n	Dublin (n=247)		Cork (n=35)		Limerick (n=35)		Galway (n=35)	
Never	30	[105]	31	[76]	34	[12]	17	[6]	31.5	[11]
Monthly or Less	14	[49]	16	[40]	6	[2]	11	[4]	9	[3]
2-4 Times a Month	13	[46]	12	[30]	20	[7]	9	[3]	17	[6]
2-3 Times a Week	20	[69]	21	[51]	3	[1]	17	[6]	31.5	[11]
4+ a Week	23	[83]	20	[50]	37	[13]	46	[16]	11	[4]
Missing		[3]		[-]		[1]		[1]		[1]

Table 5.2 demonstrates frequency of alcohol consumption by gender. As conveyed, a greater proportion of males reported alcohol consumption in excess of 4 times a week. Twenty-six percent of males (n=63) reported this consumption in comparison to 18% of the female respondents (n=20).

Table 5.2 Frequency of Alcohol Consumption by Gender

	Male (n=241)		Female (n=111)		Total (n=352)	
	%	n	%	n	%	n
Never	24	[57]	43	[48]	30	[105]
Monthly or Less	14	[33]	14	[16]	14	[49]
2-4 Times a Month	14	[33]	12	[13]	13	[46]
2-3 Times a Week	22	[55]	13	[14]	20	[69]
4+ a Week	26	[63]	18	[20]	23	[83]
Missing Observations		[3]		[-]		[3]

In terms of accommodation type, those staying in squats (i.e. derelict/unused buildings etc.) and sleeping rough reported a higher frequency of alcohol consumption in terms of use in excess of 4 times a week.

Table 5.3 Frequency of Alcohol Consumption by Accommodation Type

Accommodation	Hostel (n=174)		B&B (n=69)		S. Rough (n=56)		F & Rel (n=12)		Squat (n=6)	
	%	n	%	n	%	n	%	n	%	n
Never	25	[44]	38	[26]	27	[15]	17	[2]	33	[2]
Monthly or Less	12	[21]	16	[11]	23	[13]	8	[1]	17	[1]
2-4 Times a Month	16	[27]	10	[7]	5	[3]	25	[3]	17	[1]
2-3 Times a Week	23	[40]	19	[13]	14	[8]	25	[3]	-	-
4+ a Week	24	[42]	17	[12]	31	[17]	25	[3]	33	[2]
Missing Observations		[2]		[-]		[-]		[-]		[-]

5.3 The Alcohol Use Disorders Identification Test Screening Instrument (AUDIT)

As discussed in Chapter Three, the AUDIT questionnaire is a 10-item screening instrument designed to detect a range of drinking problems and in particular, hazardous and harmful consumption (Saunders *et al.*, 1993; Barbor *et al.*, 2001)⁵². Table 5.4 presents the results of the AUDIT screening instrument which was administered only to those who reported alcohol use at interview (n=247).

In accordance with the recommended cut off points, of those who were consumers of alcohol, 73% (n=180) scored above 8 suggesting harmful or hazardous drinking. This represents 51% of the overall total study population. As higher scores indicate greater likelihood of hazardous or harmful drinking, such may also reflect a greater severity of alcohol problems (Babor *et al.*, 2001). In this regard, nearly a half of those who reported consuming alcohol (n=121; 49%), had a score in excess of 16 which suggests a high level of alcohol problems, the majority of whom (n=103; 42%) scored 20 or above which would warrant further diagnostic evaluation for alcohol dependence (Miller *et al.*, 1992; Babor

⁵² A score of less than 8 : no problem.

A score of 8 or above : associated with harmful or hazardous drinking and is suggestive of alcohol problems.

A score of 16 or more : is likely to indicate a high level of alcohol problems.

(Miller *et al.*, 1992; Babor *et al.*, 2001).

et al., 2001). Just over a quarter (n=67; 27%) scored less than 8 indicating no alcohol problems, which represents 19% of the overall study population.

Table 5.4 Results of AUDIT Screening Instrument (n=247)

Score	Male (n=184)		Female (n=63)		Total (n=247)		% of Total Study Pop. (n=352)
	%	n	%	n	%	n	
No problem	24	[44]	37	[23]	27	[67]	19
Alcohol Problem (harmful/hazardous drinking)	76	[140]	63	[40]	73	[180]	51
High Level of Alcohol Problems	50	[93]	44	[28]	49	[121]	34

A gender breakdown of the scores is illustrated in Table 5.4.⁵³ More male respondents reported a high score than did female respondents (Score 8+ = 76% v 63%). The AUDIT does not differentiate between males and females in terms of recommended cut off points. However, it is possible to argue that a score of 10 for a woman would be associated with a greater risk of alcohol-related physical harm (Dawe and Mattick, 1997).

Table 5.5 Results of AUDIT Screening Instrument by Location (n=247)

Score	Dublin (n=171)		Cork (n=23)		Limerick (n=29)		Galway (n=24)	
	%	n	%	n	%	n	%	n
No problem	30	[51]	13	[3]	21	[6]	29	[7]
Alcohol Problem (harmful/hazardous drinking)	70	[120]	87	[20]	79	[23]	71	[17]

Further examination of the scores showed that in each city location a similarly high proportion were problematic alcohol users.

Table 5.6 shows AUDIT scores by hostel, B&B and rough sleeping accommodation. Over half of the hostel (55%) and rough sleeping (52%) population surveyed and over a third of the B&B (39%) population surveyed were problematic drinkers. Further analysis revealed that 44% (n=57) of drinkers in hostels (32% of the total hostel sample), had a score in excess of 20 which would warrant further diagnostic evaluation for alcohol dependence. Similar results were found among rough sleepers with nearly a third of the total sample (32%) warranting further investigation for dependency.

53 All percentages cited throughout the report are based on valid percentages, adjusted for missing data.

Table 5.6 Results of AUDIT Screening Instrument by Main Accommodation Type (n=214)

Score	Hostel (n=130)			B&B (n=43)			R. Sleeping (n=41)		
	%	n	%TSP*	%	n	%TSP*	%	n	%TSP*
No problem	26	[34]	20	37	[16]	23	29	[12]	21
Alcohol Problem (harmful/hazardous drinking)	74	[96]	55	63	[27]	39	71	[29]	52

*%TSP = Percentage Total Study Population in this accommodation type

Table 5.7 below conveys results of the AUDIT screening instrument by age. As illustrated, those age groups who reported the lowest rates for problematic alcohol use as a percentage of the total study population within these age groups were between the years of 20-24, 30-34 years and 45-plus years (46%). Three-fifths of individuals in the 35-44 age group were problematic alcohol users (60%).

Table 5.7 Results of AUDIT Screening Instrument by Age (n=247)

Age	Valid	Results				
		No problem		Problematic		
		%	n	%	n	% of Pop*
< 20 yrs	[n=15]	13	[2]	87	[13]	57
20-24 yrs	[n=53]	32	[17]	68	[36]	46
25-29 yrs	[n=32]	19	[6]	81	[26]	55
30-34 yrs	[n=30]	30	[9]	70	[21]	46
35-44 yrs	[n=50]	18	[9]	82	[41]	60
45+ yrs	[n=67]	36	[24]	64	[43]	46

*Presented as a percentage of the study population within this age group

5.4 Impact of Alcohol Use on Accommodation

Those who were current drinkers and staying in emergency accommodation (hostels, shelters, B&B accommodation) were asked if staff were aware of their alcohol use. Overall, 69% (n=115) reported that staff were aware of their alcohol use. In relation to the different urban locations, all drinkers in the Cork sample reported that staff were aware of their alcohol use. Similarly, in Galway (n=13; 81%) and Limerick (n=17; 68%), the majority of current drinkers reported staff were aware of their alcohol use. The Dublin sample indicated the lowest percentage with almost two-thirds of drinkers (n=74; 65%) reporting this awareness.

Eligible respondents were also asked if they had ever experienced any difficulties accessing emergency accommodation due to their alcohol use. One-fifth (n=33; 20%) of current drinkers, which represents 9% of the total study population, reported that they had experienced difficulties accessing accommodation due to their alcohol use. Although not significant, drinkers who were staying in a hostel were

proportionally more likely than those staying in B&B accommodation to report such difficulties (23% v 12%). The sample in Galway exhibited the highest percentage of those experiencing difficulties (n=5; 31%), compared to just over a fifth (n=24; 21%) in Dublin to just 3 individuals (12%) in Limerick and 1 in Cork (10%). Further analysis revealed that all of those who had reported difficulties in accessing accommodation due to their alcohol use were problematic alcohol users.

Table 5.8 illustrates the type of difficulties reported by alcohol users staying in emergency accommodation. The difficulties cited suggest that it is more often the behaviour, as a result of consumption, rather than the drinking practice itself, which can cause problems in accessing emergency accommodation.

Table 5.8 Reported Difficulties in Accessing Emergency Accommodation as a Result of Alcohol Use

Difficulties	(n=33)
	n
Refused Access- Presenting as Intoxicated/Not Allowed to Continue Drinking/Bringing Friends Back to Drink	18
Noisy, Violent, Disorderly	5
Thrown Out/Barred- Due to Drink	3
Allowances Used for Alcohol Rather than Rent	3
Rules and Regulations	2
Trouble with Police	1
Unable to Get Detox	1

The most common difficulty reported by over half of the individuals (n=18; 55%) was in relation to the refusal of access to emergency accommodation services because of either their intoxicated status upon arrival or bringing additional drink onto premises. Noisy, violent and disorderly behaviour as a result of drinking behaviour was also cited as preventing access. The following quotes illustrate some of these reported difficulties;

I was to be in by 11 o'clock but went drinking and did not get back until after one, so now I'm in trouble with the prison and hostel.

(Male, 41 years)

My behaviour, sometimes it wouldn't agree with me. It would make me violent and angry.

(Male, 19 years)

Other reported difficulties included; being barred or thrown out, money used to purchase alcohol rather than used towards accommodation costs, rules and regulations of services, trouble with the police and unable to get a detox to facilitate entry into accommodation.

5.5 Alcohol Use: the Provider Perspective

The providers perception of alcohol use is consistent with the findings of the survey among the homeless population in that alcohol was still perceived to be the main drug of use among homeless people in Cork, Galway and Limerick. This is conveyed in the following quotes:

What we have seen is that the major problem for us would be alcohol addiction.

(Homeless service provider – Cork)

There is high alcohol use among homeless people who are in hostels [...] Between the two hostels I would put the percentage at 60% of people who have alcohol-based problems.

(Homeless service provider – Limerick)

The main problem down here is a problem with alcohol. There is a lot of dual use, but alcohol is a serious, serious problem.

(Drug service provider – Galway)

Hitherto, alcohol was traditionally the drug of choice among homeless people in Dublin. However, service providers have noticed a recent change in alcohol becoming part of more complex drug using repertoires.

It would be 95-96% of the people who would use our service would be street drinkers but we have noticed that the guys who would just be street drinkers are starting to use other drugs, maybe heroin or grass, whatever.

(Day service provider – Dublin)

5.6 Alcohol and Accommodation: the Provider Perspective

For those that drink alcohol, accommodation is provided in wet hostels in Dublin and Limerick, with plans for one in Cork, and recommendations for one in Galway. While, service providers from other types of emergency accommodation stated that they operated a 'no drink' policy, there were variations regarding how much this was enforced. Most policies remained flexible to accommodate individual cases.

If someone takes a couple of cans into the sleeping area to go through the night, most of the night staff will turn a blind eye or in the morning time if someone looks like they're going into the DTs and they have a can of beer and they just take it and go somewhere quiet and drink it, it's flexible.

(Night shelter worker – Dublin)

Officially, in reality it is how much they are drinking, how obvious they are about doing it and there have been times when we have asked people to leave. Sometimes we stick to our policies quite rigidly and other times we have been quite creative.

(Hostel provider – Galway)

Therefore, individuals were more likely to be excluded from hostels for disturbing other residents or because of violent behaviour (which could be triggered by alcohol use).

Again, we don't feel it is our right to search anyone but we ask them to hand up things like alcohol. Occasionally, what happens if five people are sitting round a bed are refusing to stop partying and having a wonderful time for themselves and disturbing everyone else, they will be asked to leave the building and they will be told why they are being asked to leave the building.

(Night shelter worker – Dublin)

With the street drinkers we don't like to do permanent bans. It would have to be really something like where one of the street drinkers punched a member of staff or one of the other clients.

(Night shelter worker – Dublin)

B&Bs were seen to be less flexible around alcohol use on their premises as they felt that it was inappropriate around children, they were concerned it could disturb other residents and their insurance did not cover alcohol-related incidents. Similarly, managers of transitional housing were more stringent when enforcing a 'no-drink policy'.

If somebody was found drinking alcohol, it would depend on the person. If they were an ex-alcoholic then we might be stronger about enforcing that part of the licence agreement because it conflicts with their goals, as well.

(Worker – transitional housing – Dublin)

We've very clear criteria around drugs and alcohol. We don't take people who are actively using or who have serious mental illnesses and that is simply because we don't have the resources.

(Worker – transitional housing – Dublin)

5.7 Summary and Conclusions

- **Alcohol remains the primary drug of choice among the homeless population (70%). Frequency of alcohol consumption varies by gender and age. A greater proportion of males reported alcohol consumption in excess of four times a week in comparison to female respondents. Furthermore, those who reported alcohol use in excess of four times a week were older.**

There is a long standing relationship between alcohol use and homelessness. Alcohol problems are more common among homeless men than women, and among the older age groups (Kershaw et al., 2000). UK research indicates that alcohol use among older persons can often go undetected as it may present in ways which reflect other generic symptoms of the ageing process (Alcohol Concern, 2002). Levels of current alcohol use among the homeless are just slightly lower than the current alcohol prevalence rates for the Irish general population (70% v 74%) (NACD/DAIRU, 2004).

- **In terms of accommodation type, those staying in squats and sleeping rough reported a higher frequency of alcohol consumption in terms of use in excess of four times a week. Over half of the rough sleeping sample scored as problematic alcohol users (52%).**

This is consistent with other Irish research among homeless people which illustrates that those sleeping rough or living in squats were more likely to be heavy/very heavy drinkers (Corr, 2003a).

According to Dublin Simon (2003), alcohol use was one of the main presenting issues (22%) among outreach service users in 2002. Up to a third of people sleeping rough in the UK are heavy drinkers (Warnes *et al.*, 2003). Research from the UK has also indicated that the proportion of rough sleepers who are problematic alcohol users has decreased in recent years. This has been explained by the fact that some older drinkers have been moved off the streets while others have died from drink-related causes (Warnes, 2003).

- **Almost three-in-four current drinkers scored as problematic in accordance with the AUDIT screening instrument (73%), representing 51% of the total homeless population. Males reported a higher AUDIT score than female respondents.**

Lower figures were found in a review of UK research, which illustrate that around a third of those experiencing homelessness have an alcohol problem (Warnes *et al.*, 2003). It is necessary to apply caution when comparatively analysing the scale and nature of an alcohol problem, as terms such as 'hazardous', 'harmful' or 'problematic' may be applied to various levels or conditions according to the service using them (Alcohol Concern, 2002). Irrespective of the term applied, research on the characteristics of homeless street drinkers has highlighted this group as a distinct homeless risk group (Costello and Howley, 1999; Galway Simon Community, 1999).

- **Almost three-in-four current drinkers in the Galway sample scored as problematic alcohol users (71%), representing 47% of the total Galway sample.**

These figures found among the Galway sample are substantially higher than those included within the study undertaken by Hourigan and Evans (2003) on the health status of homeless people in the West. This research revealed that 55% of current drinkers scored 2 or greater on the CAGE alcoholism screening instrument indicating alcohol problems.

- **Those staying in hostels exhibited the highest proportion of problematic drinkers (55%), followed closely by rough sleepers (52%). Nearly two-fifths of B&B occupants exhibited problematic drinking (39%).**

This research also highlights, similar to findings from the UK (Mental Health Foundation, 1996), that problematic drinkers are not solely rough sleepers but also tend to be staying within temporary accommodation (hostels and B&B accommodation). According to Dublin Simon (2003), alcohol use was a common issue affecting over 50% of hostel residents in 2002. However, the rate of alcohol use of hostel residents varies greatly and this is partly influenced by whether or not hostels admit heavy drinkers (Warnes *et al.*, 2003:39). Under-reporting of prevalence figures may occur as there may be reluctance on the part of homeless individuals to disclose their levels of alcohol use for fear of the consequences on their present or future accommodation needs.

- **Over a third of the hostel dwelling sample and rough sleeping population (32%) scored 20 or above on the AUDIT screening instrument which warrants further diagnostic evaluation for alcohol dependence.**

Feeney *et al.* (2000) in a study of homeless hostel-dwelling men in Dublin, found that half of the group were alcohol dependent (50%) and 29% were categorised as having severe alcohol dependence. Fountain and Howes (2002), in a study of rough sleepers, found that a quarter were alcohol dependent.

- **The majority of current drinkers staying in emergency accommodation reported that staff were aware of their alcohol use (70%), with only one-fifth reporting difficulties in accessing emergency accommodation (20%). Difficulties cited suggest that it is more often the behaviour, as a result of consumption, rather than the drinking practice itself, which can cause problems in accessing emergency accommodation.**

In a study of rough sleepers in London, Fountain and Howes (2002) found that nearly two-in-five of the sample had been excluded from one or more homeless services in the past year. Physical violence was identified by service providers as a major cause of exclusions. Behavioural consequences of alcohol use are more pronounced than for any other drug types (Butler, 2003:8). Moreover, the effect of polydrug use on patterns of behaviour can often further facilitate aggressive episodes. McCormick and Smith (1995) in a study of aggression and hostility in substance users found that polydrug users scored significantly higher on all measures of hostility and aggression.

- **Service providers similarly perceived alcohol to be the main drug of use among homeless people in each city location. However, service providers have noticed a recent change in alcohol use becoming part of more complex drug using repertoires.**

Alcohol-related problems have been predominantly reported in studies of homeless persons in the past decades. The contemporary generation of homeless individuals are distinguished by reports of high rates of problem drug use in addition to alcohol use (O'Flaherty, 1996). This is primarily due to the fact that homelessness among the age group predominantly engaged in illicit drug use (those under-25 years) is a fairly recent phenomenon (Cox and Lawless, 1999).

- **Providers of emergency accommodation (with the exception of wet hostels/shelters) reported the operation of a 'no-drink policy', however most policies were flexible to accommodate for individual cases. B&B service providers interviewed reported that they were less flexible around alcohol use on premises. Service providers reported that individuals would more likely be excluded for violent or disorderly behaviour.**

It is also important that there is a clear understanding among services users regarding conditions of 'acceptable' and 'unacceptable' behaviour and the current policies and procedures which are in operation within an organisation (Flemen, 1999). Interventions which can reduce behavioural problems but which also seek to avoid excluding service users should remain at the forefront of organisational policy (Britton and Pamneja, 2000). It is argued that the creation of an enabling atmosphere within an organisation, which allows clients to express their needs, is more progressive than exclusion policies based on inappropriate behaviour patterns (Britton and Pamneja, 2000).

Chapter Six

Patterns of Drug Use

6.1 Introduction

As the main aim of the study is to examine the nature and extent of drug use among the homeless, it was considered vital to get different measures of homeless individuals drug-using status. To this end, the drug-use component incorporated various standardised drug-use scales in addition to the inclusion of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) template of lifetime, recent and current drug classifications⁵⁴.

6.2 Illicit Drug Use Among the Homeless Population⁵⁵

6.2.1 Current Illicit Drug Use by Location

Table 6.1 conveys rates of lifetime, recent and current illicit use across city locations. Almost three-in-four respondents reported lifetime use (74%), while nearly two-thirds reported use of illicit drugs within the last year (64%). Just over half of the study population reported illicit drug use within the last month (52%).

Table 6.1 Illicit Drug Prevalence Rates by Location and Gender

Illicit Drug Use	City Locations									
	Total Homeless Population		Dublin		Cork		Limerick		Galway	
	%	n	%	n	%	n	%	n	%	n
Lifetime Use	74	[261]	80	[197]	72	[26]	42	[15]	64	[23]
By Gender										
%Male	72	[176]	75	[132]	76	[16]	50	[13]	68	[15]
%Female	77	[85]	90	[65]	67	[10]	20	[2]	57	[8]
Recent Use	64	[226]	72	[179]	53	[19]	28	[10]	50	[18]
By Gender										
%Male	61	[148]	67	[118]	52	[11]	31	[8]	50	[11]
%Female	70	[78]	85	[61]	47	[8]	20	[2]	57	[7]
Current Use	52	[183]	59	[146]	42	[15]	25	[9]	36	[13]
By Gender										
%Male	49	[120]	54	[94]	48	[10]	27	[7]	41	[9]
%Female	57	[63]	72	[52]	33	[5]	20	[2]	29	[4]

Although drug users in general and illicit drug users in particular were not targeted for this study, 52% (n=183) of the total sample were currently using an illicit drug. In terms of gender distribution, males accounted for 66% (n=120) of those who reported currently using any illicit drug with females accounting for the remaining 34% (n=63). Although not significant, female respondents were proportionally more likely to report the current use of an illicit drug in comparison to their male counterparts (57% v 49%).

54 It is necessary to produce different prevalence figures which distinguish use at the present time from use that may have been in the past and discontinued after some time. If he/she has "ever used" the data produced refers to lifetime prevalence, "used" in the last 12 months refers to recent use and finally "used" within the last month refers to current prevalence.

55 For the purpose of this study, "illicit drugs" refers to cannabis, ecstasy, amphetamines, crack cocaine, cocaine powder, heroin, hallucinogens (LSD, poppers and magic mushrooms) and solvents.

Fifty-nine percent (n=146) of the Dublin sample were currently using an illicit drug. Eighty-four percent (n=123) of current illicit drug users reported use of more than one drug (i.e. polydrug use), this represents 50% of the Dublin homeless sample.

Respondents from Cork reported the next highest rate of current use (42%), while over a third of the Galway sample (36%) and a quarter of the Limerick sample (25%) reported current drug use.

6.2.2 Current Illicit Drug Use by Accommodation Type

In terms of illicit drug use by accommodation type, Table 6.2 illustrates that rough sleepers exhibited the highest percentage of current illicit use (73%) in comparison to those staying in B&B accommodation or hostels (67% and 43% respectively). This high level of illicit drug use among rough sleepers was consistent across both Dublin and non-Dublin samples. Nearly one-in-two hostel dwellers in Dublin reported current use of an illicit drug (n=52; 48%), while over two-thirds (n=44; 69%) of B&B residents were current illicit drug users. The rate of illicit drug use among B&B occupants and hostel dwellers was substantially lower outside of Dublin.

Table 6.2 Illicit Drug Use Over Past Month by Main Accommodation Type

Location	Accommodation Type					
	Hostel*		B&B*		Rough Sleeping*	
	%	n	%	n	%	n
Dublin	48	[52]	69	[44]	72	[34]
Outside Dublin	36	[24]	40	[2]	78	[7]
All Locations	43	[76]	67	[46]	73	[41]

*Percentages based on the total study population in each accommodation type

6.3 Prevalence of Use Among the Homeless Population by Drug Type

6.3.1 Total Homeless Population

As illustrated within Table 6.3 below, cannabis has the highest lifetime prevalence rate among the total homeless sample (n=243; 69%), followed by heroin and ecstasy (n=150; 42%). Lifetime use of cocaine and various sedatives was also relatively high, reported by two-in-five of all study respondents. Forty-one percent (n=146) reported lifetime use of cocaine while 40% reported lifetime use of sedatives (n=140). Over a third of the sample reported lifetime use of amphetamines (n=125; 35%) and the same proportion had used anti-depressants (n=117; 34%). Over one-in-five of the sample had used hallucinogens, methadone, and tranquillisers and nearly a fifth of all respondents reported lifetime use of crack cocaine.

Table 6.3 Drug Use Among the Total Study Population (n=355)

	Lifetime Use		Recent Use		Current Use	
	%	n	%	n	%	n
Cannabis*	69	[243]	56	[198]	43	[152]
Heroin*	42	[150]	30	[107]	22	[78]
Ecstasy*	42	[150]	22	[78]	12	[42]
Cocaine Powder*	41	[146]	28	[98]	17	[61]
Sedatives	40	[140]	33	[117]	26	[90]
Amphetamines*	35	[125]	12	[42]	2	[9]
Anti-Depressants	34	[117]	26	[91]	19	[67]
Hallucinogens*	28	[101]	4	[15]	1	[3]
Tranquillisers	26	[92]	22	[77]	16	[58]
Methadone	23	[80]	21	[72]	18	[64]
Crack Cocaine*	19	[66]	10	[35]	3	[11]
Solvents*	16	[58]	2	[8]	1	[4]
Other Opiates	11	[40]	5	[19]	3	[9]
Steroids	4	[16]	2	[9]	1	[5]
Other Drugs	4	[16]	3	[12]	2	[9]

* Denotes an illicit drug

Similarly, cannabis was the highest cited drug in terms of recent use, reported by over half of all respondents (n=198; 56%) with recent sedative (n=117; 33%) and heroin use (n=107; 30%) reported by almost a third of the total study population. Over a quarter reported the use of cocaine or anti-depressants within the last year, while over a fifth of all respondents cited recent use of ecstasy, tranquillisers or methadone.

Current use by drug type largely followed those of both lifetime and recent drug using patterns. In the last month, less than a half of the sample had used cannabis (n=152; 43%). Almost a quarter had used heroin (n=78; 22%) within the four weeks prior to interview. Over a quarter report current use of sedatives (n=90; 26%), and almost a fifth reported use of anti-depressants (n=68; 19%) and tranquillisers (n=58; 16%).

Table 6.4 presents current prevalence rates of the different drugs by three accommodation types; those staying in hostels, B&B accommodation and sleeping rough. Almost three-fifths of those sleeping rough (n=33; 59%) and over half of those in B&B accommodation (n=38; 55%) had used cannabis in the past month in comparison to just over a third of those staying in hostels (n=64; 37%). Similarly, higher rates of current use of both heroin and cocaine were observed for those sleeping rough (heroin n=19; 34%) (cocaine n=14; 25%) and among B&B occupants (heroin n=21; 30%) (cocaine n=14; 20%) in comparison to lower rates observed among hostel dwellers (heroin n=31; 18%) (cocaine n=24; 14%).

Table 6.4 Current Prevalence Rates of Drugs by Main Accommodation Type

	Hostel (n=175)		B&B (n=69)		Sleeping Rough (n=56)	
	%	n	%	n	%	n
Cannabis*	37	[64]	55	[38]	59	[33]
Heroin*	18	[31]	30	[21]	34	[19]
Ecstasy*	10	[17]	16	[11]	14	[8]
Cocaine Powder*	14	[24]	20	[14]	25	[14]
Sedatives	28	[49]	26	[18]	25	[14]
Amphetamines*	2	[4]	1	[1]	7	[4]
Anti-Depressants	19	[32]	25	[17]	18	[10]
Hallucinogens*	0	[1]	1	[1]	2	[1]
Tranquillisers	10	[17]	36	[25]	23	[13]
Methadone	16	[28]	28	[19]	18	[10]
Crack Cocaine*	1	[2]	3	[2]	7	[4]
Solvents*	0	[1]	3	[2]	2	[1]
Other Opiates	2	[4]	1	[1]	5	[3]
Steroids	2	[3]	3	[2]	-	-
Other Drugs	1	[2]	3	[2]	7	[4]

* Denotes an illicit drug

6.3.2 Dublin Homeless Population

Table 6.5 presents drug prevalence rates for the Dublin homeless sample by drug type. As conveyed, similar patterns emerged as the drug prevalence rates for the total study population. Cannabis and heroin use had the highest cited lifetime use of a drug.

Table 6.5 Drug Use Among the Homeless Population – Dublin (n=247)

	Lifetime Use		Recent Use		Current Use	
	%	n	%	n	%	n
Cannabis*	74	[183]	64	[157]	49	[121]
Heroin*	51	[127]	40	[99]	30	[74]
Ecstasy*	43	[105]	24	[60]	6	[14]
Cocaine Powder*	45	[111]	34	[83]	22	[54]
Sedatives	44	[108]	38	[94]	32	[78]
Amphetamines*	35	[85]	12	[30]	2	[4]
Anti-Depressants	31	[77]	26	[63]	19	[47]
Hallucinogens*	29	[72]	4	[10]	1	[3]
Tranquillisers	29	[71]	26	[64]	21	[53]
Methadone	31	[76]	29	[71]	26	[64]
Crack Cocaine*	19	[48]	10	[26]	4	[9]
Solvents*	15	[38]	2	[5]	1	[2]
Other Opiates	7	[18]	5	[12]	3	[7]
Steroids	4	[11]	3	[8]	2	[4]
Other Drugs	4	[11]	4	[9]	3	[7]

* Denotes an illicit drug

Rates for current use of heroin and methadone were higher than among the general study population, with 30% (n=74) and 26% (n=64) of the Dublin sample reporting current use in comparison to 22% (n=78) and 18% (n=64) of the total study population. Just over a fifth of the Dublin sample reported current use of cocaine (n=54; 22%).

Table 6.6 presents current prevalence rates of drugs within the Dublin sample by main accommodation type. Current cannabis use was the most cited drug reported by those staying in hostels, B&B accommodation and sleeping rough. Those sleeping rough in Dublin reported the highest levels of heroin (n=19; 40%) and cocaine use (n=12; 25%) followed by B&B residents (heroin: n=21; 33%) (cocaine: n=14; 22%) and then hostel dwellers (heroin: n=27; 25%). Conversely, B&B residents showed the highest levels of methadone use (n=19; 30%) followed by hostel dwellers (n=28; 26%) and then rough sleepers (n=10; 21%).

Table 6.6 Current Prevalence Rates of Drugs by Main Accommodation Type – Dublin

	B&B (n=64)		Sleeping Rough (n=47)		Hostel (n=109)	
	%	n	%	n	%	n
Cannabis*	59	[38]	55	[26]	40	[44]
Heroin*	33	[21]	40	[19]	25	[27]
Ecstasy*	17	[11]	13	[6]	11	[12]
Cocaine Powder*	22	[14]	25	[12]	18	[20]
Sedatives	27	[17]	28	[13]	38	[42]
Amphetamines*	2	[1]	2	[1]	2	[2]
Anti-Depressants	27	[17]	17	[8]	17	[19]
Hallucinogens*	2	[1]	2	[1]	1	[1]
Tranquillisers	39	[25]	2	[1]	13	[14]
Methadone	30	[19]	21	[10]	26	[28]
Crack Cocaine*	3	[2]	6	[3]	1	[1]
Solvents*	2	[1]	2	[1]	⁵⁶ -	-
Other Opiates	3	[2]	2	[1]	4	[4]
Steroids	3	[2]	-	-	2	[2]
Other Drugs	2	[1]	8	[4]	1	[1]

* Denotes an illicit drug

6.3.3 Homeless Population Outside Dublin

Table 6.7 Drug Use Among the Homeless Population – Cork (n=36)

	Lifetime Use		Recent Use		Current Use	
	%	n	%	n	%	n
Cannabis*	69	[25]	47	[17]	33	[12]
Heroin*	19	[7]	3	[1]	-	-
Ecstasy*	53	[19]	28	[10]	11	[4]
Cocaine Powder*	42	[15]	25	[9]	14	[5]
Sedatives	36	[13]	22	[8]	9	[3]
Amphetamines*	53	[19]	22	[8]	8	[3]
Anti-Depressants	36	[13]	22	[8]	14	[5]
Hallucinogens*	39	[14]	6	[2]	-	-
Tranquillisers	31	[11]	19	[4]	8	[3]
Methadone	8	[3]	3	[1]	-	-
Crack Cocaine*	25	[9]	11	[4]	6	[2]
Solvents*	31	[11]	6	[2]	3	[1]
Other Opiates	31	[11]	11	[4]	6	[2]
Steroids	6	[2]	3	[1]	3	[1]
Other Drugs	-	-	-	-	-	-

* Denotes an illicit drug

⁵⁶ No hostel dweller surveyed reported use of this drug.

Table 6.8 Drug Use Among the Homeless Population – Galway (n=36)

	Lifetime Use		Recent Use		Current Use	
	%	n	%	n	%	n
Cannabis*	61	[22]	47	[17]	33	[12]
Heroin*	33	[12]	11	[4]	6	[2]
Ecstasy*	50	[18]	14	[5]	8	[3]
Cocaine Powder*	42	[15]	6	[2]	3	[1]
Sedatives	42	[15]	31	[11]	17	[6]
Amphetamines*	42	[15]	6	[2]	3	[1]
Anti-Depressants	39	[14]	31	[11]	19	[7]
Hallucinogens*	28	[10]	6	[2]	-	-
Tranquillisers	25	[9]	14	[5]	3	[1]
Methadone	4	[1]	-	-	-	-
Crack Cocaine*	22	[8]	11	[4]	-	-
Solvents*	19	[7]	-	-	-	-
Other Opiates	28	[10]	8	[3]	-	-
Steroids	8	[3]	-	-	-	-
Other Drugs	8	[3]	6	[2]	3	[1]

* Denotes an illicit drug

Table 6.9 Drug Use Among the Homeless Population – Limerick (n=36)

	Lifetime Use		Recent Use		Current Use	
	%	n	%	n	%	n
Cannabis*	36	[13]	20	[7]	20	[7]
Heroin*	11	[4]	8	[3]	6	[2]
Ecstasy*	22	[8]	9	[3]	3	[1]
Cocaine Powder*	14	[5]	11	[4]	3	[1]
Sedatives	11	[4]	11	[4]	9	[3]
Amphetamines*	17	[6]	6	[2]	3	[1]
Anti-Depressants	36	[13]	25	[9]	22	[8]
Hallucinogens*	14	[5]	3	[1]	-	-
Tranquillisers	3	[1]	3	[1]	3	[1]
Methadone	-	-	-	-	-	-
Crack Cocaine*	3	[1]	3	[1]	-	-
Solvents*	6	[2]	3	[1]	3	[1]
Other Opiates	3	[1]	-	-	-	-
Steroids	-	-	-	-	-	-
Other Drugs	6	[2]	3	[1]	3	[1]

* Denotes an illicit drug

As demonstrated above, lifetime prevalence rates by the different drug types were largely similar across both Cork and Galway homeless samples. Respondents in Cork and Galway reported higher lifetime use of cannabis (69% and 61% respectively) in comparison to only 36% of the Limerick sample. Similar variations were observed in terms of lifetime use of cocaine/crack, amphetamines and ecstasy use. Lifetime heroin use was higher in Galway (n=12; 33%) than in either Cork (n=7; 19%) or Limerick (n=4; 11%). Lifetime use of anti-depressants was highest in Limerick of all the city locations with over one-third (36%) of the sample reporting its use. In Galway, ecstasy was the second most used lifetime drug, while in Cork both ecstasy and amphetamines were the second most used lifetime drug.

In terms of recent use, nearly a half of the Cork (n=17; 47%) and Galway (n=17; 47%) sample reported having used cannabis in the last year, while only a fifth reported such use in Limerick (n=7; 20%). Nearly a third (n=11; 31%) of the respondents in Galway reported use of sedatives and tranquillisers, while the use of anti-depressants was generally high in each location. Recent use of cocaine, ecstasy and amphetamines were highest for the Cork homeless sample. In terms of crack cocaine, four respondents in both Cork and Galway had used crack in the last year in comparison to only one respondent in Limerick.

As presented in Tables 6.7, 6.8 and 6.9, cannabis was the most cited current drug used in Cork and Galway, while in Limerick anti-depressants were the most cited current drug used. Anti-depressant medication was the second most cited current drug by the homeless sample in Galway, while in Cork 14% of the respondents (n=5) reported current use of anti-depressants and cocaine. There was no use of heroin within the month prior to interview among the Cork sample with only very limited use in Galway and Limerick. This is in comparison to a 30% current heroin prevalence rate for the Dublin homeless sample.

6.4 Frequency of Use Over Past Month⁵⁷

Respondents who had used any of the cited drugs (licit or illicit) in the last month were asked to specify their frequency of use. Table 6.11 illustrates how often individuals reported the use of their specified drugs over the four weeks prior to contact.

Table 6.10 Frequency of Use Over Past Month

Current Use	Valid Missing		1-3 days		4-9 days		10-19 days		20 days +	
			%	n	%	n	%	n	%	n
Cannabis*	[151]	[1]	23	[35]	20	[30]	8	[12]	49	[74]
Sedatives	[82]	[8]	26	[21]	13	[11]	9	[7]	52	[43]
Heroin*	[77]	[1]	19	[15]	8	[6]	21	[16]	52	[40]
Anti-Depressants	[61]	[6]	31	[19]	5	[3]	3	[2]	61	[37]
Methadone	[60]	[4]	28	[17]	7	[4]	3	[2]	62	[37]
Cocaine Powder*	[58]	[3]	43	[25]	24	[14]	9	[5]	24	[14]
Tranquillisers	[54]	[4]	28	[15]	11	[6]	5	[3]	56	[30]
Ecstasy*	[42]	[-]	52	[22]	17	[7]	10	[4]	21	[9]
Crack Cocaine*	[10]	[1]	60	[6]	-	-	-	-	40	[4]
Other Opiates	[7]	[2]	28.5	[2]	28.5	[2]	-	-	43	[3]
Amphetamines*	[7]	[2]	86	[6]	-	-	-	-	14	[1]
Other Drugs	[7]	[2]	-	-	-	-	14	[1]	86	[6]
Steroids	[4]	[1]	50	[2]	-	-	-	-	50	[2]
Hallucinogens*	[2]	[1]	-	-	-	-	50	[1]	50	[1]
Solvents*	[4]	[-]	50	[2]	-	-	-	-	50	[2]

* Denotes an illicit drug

The majority of current heroin users reported using heroin in excess of 20 days (n=40; 52%) which represents 11% of the total study population. Sixty-two percent (n=37) of current methadone users, which relates to 10% of the total homeless population, reported frequency of use in excess of 20 days. The frequency of current use of sedatives and anti-depressants was also quite high, with 52% and 61% respectively reporting use of 20 days or more within the last month. Less than one-in-four of current users of cocaine and ecstasy reported use in excess of 20 days, while the majority of current crack users (60%) reported use of 1-3 days within the last month.

⁵⁷ Frequency of current use is categorised in accordance with the EMCDDA classification.

6.5 Prescription Medication Among the Homeless Population⁵⁸

6.5.1 Prescribed Medication by Location

Table 6.12 demonstrates that over a third of the total study sample reported the current use of prescribed medication (n=129; 36%). Although not significant, those who reported current use of prescribed medication were more likely to be in contact with psychiatric services (47% v 38%). The figure for the Dublin sample was slightly higher with nearly two-in-five reporting current use of prescribed medication (n=95; 39%). Although not significant, females were more likely than their male counterparts to report the use of prescribed medication (44% v 37%). Furthermore, those who had been diagnosed with a psychiatric illness were significantly more likely to report prescribed medication ($\chi^2 = 10.25$; $df=1$; $p<0.01$). Just over a third (n=35; 37%) of those in receipt of prescribed medication had been diagnosed with a psychiatric illness.

Table 6.11 Prescribed Medication Over Past Month

Location	Prescribed Drug Use*	
	%	n
Dublin	39	[95]
Outside Dublin	31	[34]
Limerick	47	[17]
Galway	36	[13]
Cork	11	[4]
Total	36	[129]

*Expressed as a percentage of the total study population

6.5.2 Prescribed Medication by Drug Type

As illustrated in Table 6.13 below, anti-depressants were the most cited prescribed drug with 15% of the total study population reporting their prescribed use, followed by sedatives (14%) and methadone (12%). However, an analysis of those currently on methadone, show that only just over two thirds reported prescribed current use. This means that just less than one-in-three were obtaining "street" methadone.

⁵⁸ Respondents were asked whether their use of the following drugs was as a result of them being prescribed to them.

Table 6.12 Prescription Medication by Drug Type

Drug Type-Current Use	Current Use of Prescription Medication		Prescribed Drug Use as a % of Current Use		Prescribed Drug Use as a % of Total Study Population
	Valid	Missing	%	n	%
Anti-Depressants	[66]	[2]	80	[52]	15
Methadone	[62]	[2]	69	[43]	12
Tranquillisers	[57]	[1]	56	[32]	9
Sedatives	[90]	-	53	[48]	14
Steroids	[5]	[5]	40	[2]	1
Other Opiates	[9]	-	33	[3]	1
Other Drugs	[8]	[1]	88	[7]	2

* Total exceeds 100% as multiple responses were allowed.

6.6 Polydrug Use Among the Homeless Population

6.6.1 Polydrug Use by Location

Table 6.14 illustrates the polydrug using status of the study population. It highlights a mean use of 3 drugs among those who reported current drug use within the overall homeless sample (includes both licit and illicit but excludes alcohol).

Table 6.13 Polydrug Use by Location

Location	Number of Drugs			
	Mean	Median	Mode	Range
Dublin	3.33	3	1	1-10
Outside Dublin	1.98	1	1	1-9
Cork	2.47	2	1*	1-9
Galway	1.89	1	1	1-6
Limerick	1.59	1	1	1-5
Total	3	3	1	1-10

*Multiple modes exist. Smallest shown

Analysis revealed that among those who reported the current use of drugs within the overall study sample, only 28% were using one drug type which represents 17% of the overall study population. The remaining 72% of current drug users were using in excess of one drug which represents 45% of the overall study population.

The mean number of drugs reported by drug users outside of Dublin was considerably lower than that reported by the Dublin drug using respondents (1.98 v 3.33). Outside Dublin, Cork reported the highest mean number of drugs currently used. Furthermore, one-in-four of current drug users within the Dublin sample reported using five or more drugs. This represents 25% of the current drug-using

sample in Dublin and 17% of the overall Dublin homeless sample (n=43). This is in comparison to 6% of the current drug-using sample outside of Dublin and 3% of the overall non-Dublin homeless sample (n=3). Further analysis revealed that female drug-using respondents reported a slightly higher mean number of drugs than their male drug-using counterparts (mean no. of drugs; 3.2 v 2.9).

6.6.2 Polydrug Use and Accommodation

Table 6.14 Polydrug Use by Main Accommodation Type

Accommodation	Number of Drugs			
	Mean	Median	Mode	Range
Hostel	2.8	3	1	1-7
B&B	3.3	3	2	1-10
Sleeping Rough	3.2	3	1	1-9

Of those who reported current drug use, 19% of hostel dwellers reported use of five drugs or more in comparison to 23% of B&B occupants and 26% of rough sleepers. In terms of a percentage of the total accommodation samples of hostel dwellers, B&B occupants and rough sleepers, this represents 11%, 17% and 20% respectively.

6.7 Problematic Drug Use Among the Homeless Population

As illustrated in Chapter Three, the Drug Abuse Screening Test (DAST) is a 10-point scale used to identify problematic drug use. This screening instrument was only administered to individuals who had used a drug within the last 12 months in accordance with the definition provided (n=216)⁵⁹. A score of six or more indicates a drug problem (Gavin *et al.*, 1989).

6.7.1 Problematic Drug Use by Location

Table 6.15 illustrates levels of problematic drug use by location. Almost two-thirds of recent drug users scored as problematic (n=127; 65%). This relates to 36% (n=127) of the homeless population who scored as problematic drug users according to the DAST screening instrument. Problematic drug users were proportionally more likely to be polydrug users than their non-problematic drug-using counterparts (77% v 40%).

As a percentage of recent users, Limerick exceeded all other city locations in terms of problematic drug use. However, in terms of the total homeless population, the percentage of the Dublin homeless sample who scored as problematic was far higher than the figure for other cities. Over two-fifths of the Dublin sample (43%) scored as problematic in comparison to less than a fifth for those outside of Dublin (19%). Across non-Dublin locations, Cork exhibited the highest score for problematic drug users as a percentage of the homeless sample (25%), followed by Limerick (19%). Thirty-three percent of those who were administered the DAST screening instrument within the Galway sample scored as problematic, which represents 14% of the overall Galway homeless population.

59 "Drug Use" according to the DAST instrument refers to; (1) the use of prescribed drugs or over the counter drugs in excess of the directions (2) Any non-medical drugs (including cannabis, solvents, tranquillisers, barbiturates, cocaine, stimulants, hallucinogens or opiates (Gavin *et al.*, 1989).

Table 6.15 Problematic Drug Use by Location

Location	% of Recent Drug Users		% of Homeless Population
	%	n	
Dublin	68	[106]	43
Outside Dublin	50	[21]	19
Cork	50	[9]	25
Limerick	78	[7]	19
Galway	33	[5]	14
Total	65	[127]	36

6.7.2 Characteristics of Problematic Drug Users

Table 6.16 illustrates a comparative analysis of problematic drug users and the total study population across different variables. Problematic drug users were significantly more likely to be younger than their non-problematic drug-using counterparts (t -test = 3.72; df =195; p <0.01). Problematic drug users reported a mean age of 28.2 years in comparison to 33.6 years for non-problematic drug users. Moreover, as conveyed in Table 6.16, the mean age was also lower than that reported by the total study population (mean age= 35.3 years). Male and female problematic drug users similarly reported a lower mean age than those reported by male and female respondents of the total study population.

Table 6.16 Key Variables by Homeless and Problematic Drug-Using Populations

Variable	Homeless Population (n=355)	Homeless Problematic Drug Users (n=127)
	Mean (yrs)	Mean (yrs)
Age	35.3	28.2
Gender		
Male	37.4	28.9
Female	30.4	27.1
Age First Homeless	27.4	20.5
Length Currently Homeless	2.5	2.4
	%	%
Current Accommodation		
Hostel	50	43
B&B Accommodation	19	28
Rough Sleeping	16	21
First Experience of Homelessness	41	33
Main Reason for Homelessness (Drug Use)	19	44
Currently on LA Housing List	68	65
Ever Experienced Imprisonment	55	82

Table 6.16 also shows the current accommodation type of those who scored as problematic on the DAST screening instrument. Over two-fifths of problematic drug users were staying in hostel accommodation (n =54; 43%) and over a quarter in B&B accommodation (n =35; 28%).

Analysis also revealed that problematic drug users became homeless at a younger age than the total study population (mean age 20.5 years v 27.4 years). No differences were observed in length of time homeless. Problematic drug users were proportionally more likely than the total study population to report previous experiences of homelessness (67% v 59%). Eighty-two percent (n=103) of problematic drug users reported prior imprisonment in comparison to just over a half of the total study population (n=193; 55%). No main differences were observed in term of current registration on a local authority housing list between the two groups. Sixty-five percent (n=83) of problematic drug users were registered in comparison to 68% (n=240) of the total study population.

6.8 Dependent Drug Use Among the Homeless Population

The Severity of Dependence Scale (SDS) is a five-point scale designed to measure the degree of dependence on a variety of drugs. It allows for general screening of dependence without necessarily knowing which substances are being used. It is a measure of dependence which focuses on control of use, anxiety of use and difficulty in stopping. The higher the score, the greater the degree of psychological dependence. Maximum score obtainable is 15 (Gossop *et al.*, 1995). Table 6.17 below illustrates the results of this screening instrument administered to recent drug users by location (n=193).

Table 6.17 Dependent Drug Use by Location

Score	Level of Dependence									
	All Locations (n=193)		Dublin (n=151)		Cork (n=18)		Galway (n=15)		Limerick (n=9)	
	%	n	%	n	%	n	%	n	%	n
0-5	32	[61]	27	[41]	44	[8]	67	[10]	22	[2]
6-10	25	[48]	25	[37]	28	[5]	20	[3]	34	[3]
11-15	43	[84]	48	[73]	28	[5]	13	[2]	44	[4]
Missing		[23]		[21]		[1]		[-]		[1]
Mean Score		8		8.6		6.3		3.8		8.4

Overall, 43% (n=84) of recent drug users scored between 11-15 on the screening instrument indicating high psychological dependence on the drugs used, which is 24% of the total homeless population.

Table 6.17 shows that the Dublin drug-using sample scored the highest on the SDS screening instrument with nearly half the sample scoring 11-15 indicating a high degree of psychological dependence on the drugs currently used. This represents 30% of the total Dublin study population.

As conveyed in Table 6.18, the mean score for the Dublin drug using sample was slightly higher than for the total drug-using population (8.6 v 8).

Limerick also exhibited a high proportion of dependent drug users (n=4; 44%) which represents 11% of the total Limerick sample. As already revealed, Limerick also reported the highest percentage of individuals currently on prescribed medication outside of Dublin.

In terms of level of drug dependence by accommodation type, B&B drug-using occupants scored the highest level of dependence, with 51% scoring in the 11-15 point range, followed by rough sleeping (44%) and hostel dwellers (39%). Furthermore, a mean score of 9 for B&B occupants was higher than for either of the other two accommodation types (7.6 and 7.7 respectively). Further analysis revealed that although not significant, drug-using females reported a higher mean than their male drug-using counterparts (8.5 v 7.6). Moreover, as illustrated in the previous chapter, over a third (37%) of the female study population were currently staying in B&B accommodation which may have influenced this finding.

Table 6.18 Dependent Drug Use by Main Accommodation Type

Score	Level of Dependence					
	Hostel (n=84)		B&B (n=49)		Rough Sleeping (n=39)	
	%	n	%	n	%	n
0-5	35	[29]	20	[10]	39	[15]
6-10	26	[22]	29	[14]	17	[7]
11-15	39	[33]	51	[25]	44	[17]
Mean	7.7		9		7.6	

6.9 Drug Using History

6.9.1 First Drug Used

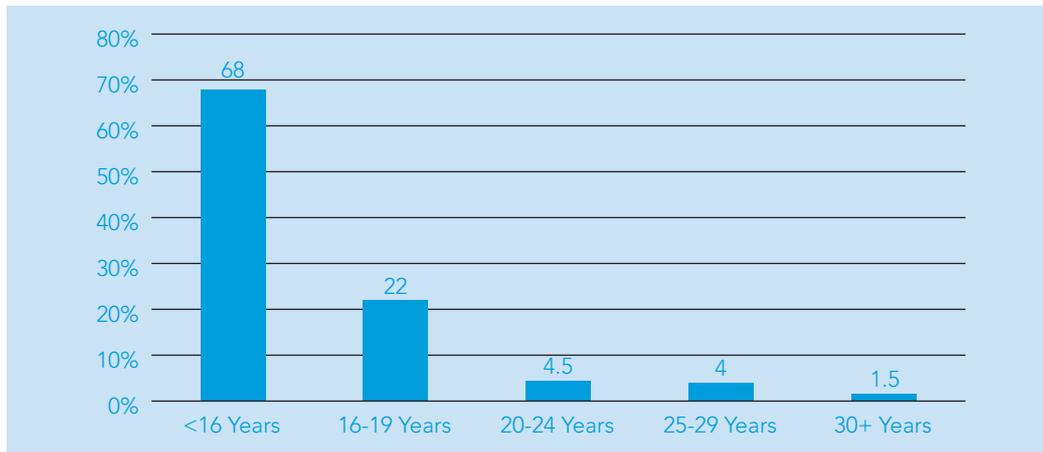
Individuals who were administered the DAST and SDS screening instruments were asked an open-ended question concerning the first drug they ever used. Over two-thirds reported that cannabis was the first drug they used (n=146; 76%). Thirteen current drug users cited solvents as the first drug used (6%). A minority of respondents (5%) also reported commencing their drug-using careers with heroin use. Further analysis revealed that of those who initiated their drug use with heroin, all but one of the respondents reported that this was the first drug ever injected (88%). The range of drugs first used by the Dublin sample is far greater than those reported by homeless individuals in any of the three other urban locations⁶⁰.

6.9.2 Age First Used Drug

Individuals who had used in the month previous were asked at what age they initiated use of their first drug. Figure 6.1 illustrates that over two-thirds of current users were less than 16 years when they first used drugs (n= 136; 68%). The mean age for first drug use was 15 years and the mode age was 14 (range 7 to 43 years). This is similar to the mean age of reported first alcohol use. Analysis revealed that there was no significant difference between the age at which male (14.69 years) and female (15.36 years) current users initiated drug use.

⁶⁰ Although alcohol was included as a first drug it was not however explicitly stated to respondents. Alcohol use was not generally regarded by the majority of individuals as being a drug. Furthermore, the fact that the question was asked only to those who had used one of the drugs in the last month may also result in under-reporting of alcohol as the first drug used.

Figure 6.1 Age of First Drug Use



6.9.3 First Use of Drugs and Becoming Homeless

Current users were also asked if they had first used drugs either before or after becoming homeless. The majority reported first using drugs before they became homeless (n=176; 87%) with the remaining 13% (n=26) commencing use following homelessness. This association is consistent with earlier findings outlined in the previous chapter which highlighted that drug use was the main or one of the secondary factors for first becoming homeless. Mean age of first drug use was lower for those who reported drug use prior to homelessness (15 years v 24 years).

6.10 Impact of Drug Use on Accommodation

Those who were current drug users (defined by licit or illicit use) and staying in emergency accommodation (hostel, B&B) were asked if staff were aware of their drug use. All those asked in Cork reported that emergency accommodation providers were aware of their drug use. However, of those who were current drug users and staying in emergency accommodation in Dublin, just over one-in-two reported this awareness (n=59; 58%). Similarly, only 50% (n=4) and 46% (n=6) respectively reported staff awareness of their drug use in Galway and Limerick. Overall, figures relating to staff awareness of their current drug-using status were lower in all locations, with the exception of Cork, than awareness relating to their current alcohol status. For example, as presented earlier in this chapter, nearly two-thirds (n=74; 65%) of current drinkers staying in emergency accommodation in Dublin reported that staff knew of their alcohol use in comparison to only 58% (n=59) who knew of individual's drug-using status.

Eligible respondents were also asked if they had ever experienced any difficulties accessing emergency accommodation due to their drug use. Overall, 30% (n=38) of current drug users staying in emergency accommodation (hostel and B&B accommodation) reported that they had experienced difficulties accessing accommodation due to their drug use, which represents 11% of the total study population. Two of the 5 current drug users (40%) staying in emergency accommodation in Cork reported difficulties accessing accommodation, in comparison to 23% (n=3) in Galway and no difficulties reported in Limerick.

Table 6.19 illustrates the type of difficulties reported by drug users staying in emergency accommodation. The most common difficulty was the fact that accommodation was refused based on an individual's drug using status. An almost similar number of individuals reported difficulties in relation to refusal of access based on their intoxicated state upon arriving at an emergency accommodation service. Lack of money to fund accommodation was also reported and it was stated by 8 individuals that they would prefer to spend their money on drugs rather than accommodation. Participation on a methadone programme was viewed as both a difficulty by some individuals and facilitated access to services by others. In other words, various homeless persons stated that emergency accommodation such as B&B accommodation would refuse access if they were on a methadone programme, while some hostels would look favourably on these individuals indicating a degree of stability in their drug use.

Table 6.19 Reported Difficulties in Accessing Accommodation as a Result of Drug Use

Difficulties	(n=38)
	n
Refused Access- Being a Drug User	[8]
Refused Access – “goofing”/ “in a bad way”	[7]
No Money For Accommodation-Spent Money on Drugs	[7]
On a Methadone Programme	[4]
Lack Trust and Not Reliable	[3]
Lost Accommodation – “got thrown out”/“barred”	[4]
Wait Longer	[2]
Not On a Methadone Programme/ Not Drug Free	[2]
Caught Injecting	[1]

The following quotes reflect the impact that an individual's drug use can have on their ability to access, and stay within, emergency accommodation services.

They said that I can't be trusted, they said that all junkies are the same.

(Male, 24 years)

I was asked if I was on drugs, I answered honestly, they refused access and said they would not house me.

(Male, 18 years)

I lost the house over my methadone being in the fridge.

(Male, 28 years)

6.11 Drugs and Accommodation: the Provider Perspective

The focus groups provided a range of opinions on providing accommodation for homeless drug users. All accommodation providers interviewed operated a 'no drugs' policy.

In London there are specific hostels for people who are on drugs and they can shoot up in safety. Here, we don't have that facility – the law is very grey on whose responsibility it is if somebody is using on the premises. It is very dodgy. We're doing a lot of research on it at the minute to try and determine a clear policy on where we stand on this.

(Homeless service provider – Cork)

As the above quote highlights, it was mainly the legal aspects that were of greatest concern to homeless service providers. Some accommodation providers had even consulted with the police when formulating their policies.

It is being dictated by law. By law we all have to have a 'no drugs on the premises' policy. The difference is how you deal with it then, after that.

(Accommodation service provider – Dublin)

We have got guidelines from the police about finding drugs on the premises. Legally, it is okay in terms of what we do. If you discover it you can ask the person to leave with their drugs and they must stay out for the night or you can dispose of them down the toilet, witnessed and signed by two members of staff. As far as I know we are covered. We don't search people.

(Night shelter provider – Dublin)

One service provider working with young homeless people emphasised that the law was particularly problematic around providing accommodation to young homeless drug users.

It would be great if there was a residential unit that would focus on the active drug users but it has all kinds of implications as well, they are under age, you have the Child Protection Act, having under 18's being allowed to use drugs by law, you cannot do that. The Child Protection Act makes it very hard to work with active drug users and to acknowledge them as such.

(Service provider – Under 18s – Dublin)

Some emergency accommodation did accept homeless drug users, as long as they complied with the rules and regulations of the hostel. Different sanctions were implemented if people were caught using drugs or dealing. These included confiscating and disposing of drugs, written warnings and barring (ranging from periods of 1 night to permanent exclusion).

If someone is dealing on the premises we will deal with that. If behaviour is going on we will challenge it. If someone uses on the premises we will issue a warning.

(Hostel provider – Dublin)

If you are found dealing drugs on the premises you are excluded from our building permanently. If you are found shooting up in our building you would be excluded from our building permanently.

(Night shelter provider – Dublin)

Many accommodation providers generally showed a preference for working with alcohol users or those on prescription drugs, as opposed to drug users, although one hostel provider pointed out that it was often alcohol use that caused problems in the hostel, not drug use.

We work with active drug users, people on methadone maintenance, drinkers, whoever. I would rather work with thirty drug users any day than two or three street drinkers [...] generally when we have to call the guards it's for drinkers or behaviour when people are under the influence, not the drug use thing and sometimes mental health.

(Hostel provider – Dublin)

We certainly wouldn't have the wherewithal or staff in general to be able to tolerate supporting somebody who is substance abusing without being on some sort of a maintenance programme. We will work with women who are engaging or misusing alcohol or misusing prescription drugs. If they are willing to work with somebody.

(Accommodation service provider – Limerick)

It was surprising to find such high levels of drug use among those living in B&Bs, as B&B providers were most adamant not only about their 'no drug' policy but also in their exclusion of drug users from their accommodation.

We hope to find out if they are drug users because firstly there are a lot of children, families and single parents, and secondly by law we are not covered by insurance to provide accommodation for a drug user or an alcoholic [...] Drug users bring the law to your house on a constant basis. If it's not for one thing it's another.

(B&B provider – Dublin)

Some accommodation providers were reluctant to work with homeless drug users as they felt drug users create too many problems for staff, they have the potential to be violent and aggressive and there are also legal problems, insurance issues and safety concerns. The following quotes exemplify this.

Unfortunately we cannot cope with people who are on hard core drugs or injecting as we don't have the facilities and they tend to hide needles in blankets and toilet rolls and it causes major problems for staff.

(Night shelter provider – Dublin)

We don't take drug users at all. We can't really control their behaviour in the hostel – they are aggressive. We are not supposed to take active drug users. Drinkers yes, there would be quite a few drinkers.

(Hostel provider – Dublin)

We don't take people who are actively using or who have serious mental illnesses and that is simply because we don't have the resources.

(Transitional housing worker – Dublin)

There was a strong agreement among service providers, however, that drug users should not be accommodated in the same places as children. The following comment sums up the general impression given by respondents.

If they are sharing accommodation with a separate kitchen it might be okay on an adult basis but with children it's not because they are dangers to themselves, to other people in the house and an awful danger to children. No child should be sitting at her table having her mother's dinner and looking up at somebody who is just after shooting up and falling on the floor and falling asleep. It's not really an environment for children [...] so families should not be placed with drug users or alcoholics. I think that is a major factor – it will have to change.

(B&B service provider – Dublin)

6.12 Nature and Extent of Drug Use: the Provider Perspective

In all four cities, there was a general consensus among drug and homeless service providers that there was a drug problem among the homeless population and that it was growing. The views of the service providers reflect the results of the survey which found that over a third of the homeless population illustrated levels of problematic drug use, with almost a quarter indicating high psychological dependence.

I think that broadly speaking there is a problem. If you look at the profile of the homeless population in the last year or two, without a doubt it is getting younger and without a doubt there is more drug use.

(Homeless service provider – Cork)

Clients are maybe drinking and taking drugs – which is worse because they are taking more of everything rather than maybe focusing on heroin or getting on a maintenance programme and taking methadone. Heroin, drink and pills. The range that is out there – there is more and more on offer to them so they are just using more and again it is very chaotic.

(Drug service provider – Dublin)

Nevertheless, service providers outside Dublin still felt that the prevalence of illicit drug use among homeless people in Cork, Galway and Limerick was still lower than it is in Dublin. Similarly, the results of the survey found much higher rates of current illicit drug use in Dublin than in the other four cities.

The percentage of illicit substance misuse would be far lower here than it would be on the Dublin scene with homeless individuals. That is because it is a smaller population and we are a bit behind in catching up.

(Homeless service provider – Limerick)

Some addiction counsellors in Galway and Cork reported that homeless people had presented with 'serious psychotic episodes' as a result of continual cannabis use or 'in a bad state after seizures' as a result of a combination of cannabis and ecstasy use. However, most service providers reported that the use of cannabis and ecstasy was widespread and now a "normal" part of the homeless culture.

They are using hash like a packet of cigarettes – it is so commonly used around the place. It is not even seen as a problem. When you ask them how much they smoke they say "I smoke twenty cigarettes a day" and then you ask about cannabis – "three or four a day" [...] cannabis is not perceived as a problem.

(Homeless service provider – Cork)

There is a lot of cannabis being smoked [...] Cannabis is just smoked like cigarettes for some of our clients and a lot of it is accepted. The number of referrals we get would not indicate the amount that is being smoked but we would know that an awful lot of our people smoke and have no problem with it [...] For me at the moment it would be ecstasy and cannabis that are widespread and are normalised to a huge degree so it would not even be an issue for a lot of people.

(Drug service provider – Galway)

According to service providers in Dublin, heroin is a serious problem among the homeless population which was reflected in the results of the survey. Many felt that at least half their client group had been, or were current, heroin users.

Everybody gives me a drug history and the majority that are actively using, which would be maybe about 60% of the patients that I have seen so far, would use heroin.

(Primary health care provider – Dublin)

It is hard to quantify exactly how many people you are dealing with. On a typical day, I would say that about 50% would have experience of using heroin and they would be intravenous drug users.

(Worker in drop-in centre – Dublin)

Outside Dublin, heroin use was perceived to be increasingly visible in Limerick, and less so in Galway and Cork. It was generally considered that many of the heroin users in these areas had come from Dublin or the UK.

It [heroin] would not even be an issue for a lot of people and also then our heroin population seems to be growing but not presenting, most would be smokers, those presenting would be smokers and in general they would be people who have relocated from Dublin or the UK.

(Drug service provider – Galway)

According to the service providers, cocaine is becoming increasingly popular among the general drug using population in the four cities as well as the neighbouring rural areas. In this regard, there is potential for cocaine use to spread among the homeless population as a drug of choice.

Cocaine would be just over the last couple of months but previous to that heroin and alcohol would be more prevalent in the homeless population that we would see.

(Drug service provider – Dublin)

There is a small bit of cocaine and it is increasing. It is much cheaper of late, so that is the pattern in this area, certainly in the area that I work in which is the North Cork area.

(Drug service provider – Cork)

Several service providers commented that many heroin users had changed their primary drug of use to cocaine, while others were using 'speedballs' (combination of heroin and cocaine).

Service providers in Dublin reported that a substantial proportion of homeless people were on methadone maintenance. It was perceived to be particularly prevalent among those living in B&Bs. This is consistent with the results from the survey among the homeless population which found that over a quarter of the Dublin sample were currently using methadone, with B&B residents reporting the highest level of methadone use. Conversely, service providers in Limerick and Galway felt that only a small proportion of their clients were on methadone, while methadone maintenance is only available in Cork for those who have moved to the area and wish to continue with their treatment.

Almost one-fifth of those surveyed reported polydrug use. This pattern was highlighted by several service providers during the focus groups who stressed that many homeless drug users were polydrug users, often mixing a range of illicit drugs with benzodiazepines and anti-depressants.

I cannot think of any client now on methadone who is not taking something else.

(Drug service provider – Dublin)

6.13 Overview of Key Findings

Table 6.20 Nature and Extent of Drug Use Among the Homeless Population

Variable	Total Study Population	City Locations			
	(n=355)	Dublin (n=247)	Cork (n=36)	Limerick (n=36)	Galway (n=36)
	%	%	%	%	%
Lifetime Illicit Use*	74	80	72	42	64
Recent Illicit Use*	64	72	53	28	50
Current Illicit Use*	52	59	42	25	36
Current Alcohol Use	70	69	66	83	68
Problematic Alcohol Use	51	49	56	64	47
Problematic Drug Use**	36	43	25	19	14
Problematic Alcohol and Drug Use	18	19	25	17	6
Dependent Drug Use (high degree of psychological dependence)	24	30	14	6	11
Ever Injected	35	46	9	9	11
Current Injectors	19	27	-	-	-

*For the purpose of this study, "illicit drugs" refers to cannabis, ecstasy, amphetamines, crack cocaine, cocaine powder, heroin, hallucinogens (LSD, poppers and magic mushrooms) and solvents.

**Drug Use is all drugs excl. alcohol as follows: Cannabis, ecstasy, amphetamines, crack cocaine, cocaine powder, heroin, hallucinogens (LSD, poppers and magic mushrooms), solvents tranquillisers, sedatives, anti-depressants, methadone, other opiates, steroids and other drugs.

6.14 Summary and Conclusions

- **Nearly three-in-four homeless individuals reported lifetime use of an illicit drug (74%). Cannabis was the most reported lifetime drug (69%).**

Lifetime prevalence of an illicit drug among the homeless is substantially higher than figures for the general population with almost one-in-five of the Irish general population (15-64 years) having reported ever taking an illegal drug (19%)(NACD/DAIRU, 2003). Similarly cannabis was the most commonly used illegal drug, however less than a fifth of the general Irish population reported lifetime use (18%) (NACD/DAIRU, 2003). Lifetime prevalence rates have varied significantly across studies among the homeless population due to methodological differences or the location or context in which the research takes place (O’Gorman, 2002). This figure for lifetime drug use is substantially higher than that found by Holohan (1997), Feeney *et al.* (2000), Condon (2001) and Smith *et al.* (2001). However, these studies focused on specific groups of homeless people. These studies similarly reported cannabis as the most commonly used illicit drug.

- **Over half of the total study population reported current illicit drug use (52%). Current use of illicit drugs among the homeless population largely followed those of both lifetime and recent drug-using patterns. Cannabis is the primary illicit drug of current use among the homeless population (43%). Almost a quarter were currently using heroin (22%).**

Findings of the national drug population study in Ireland found that one-in-eighteen (5.6%) reported cannabis use in the previous year while one-in-thirty-three (3%) reported use in the previous month. Prevalence rates for other illegal drugs were considerably lower (NACD and DAIRU, 2003). For example, only .1% of all adults aged 15-64 years had used heroin in the last month in comparison to a rate of 22% as cited above, among the homeless population under investigation. This supports other Irish research on the homeless population which has illustrated current cannabis use as the most frequently used illicit drug (Cleary and Prizeman, 1998; Feeney *et al.*, 2000; Smith *et al.*, 2001). Rates of current heroin use are higher than those found by Cleary and Prizeman (1998) in a survey of 50 homeless service users in Dublin City (15%).

- **The majority of current illicit drug users reported use of more than one drug (84%). Overall, this represents 50% of the Dublin homeless sample. One-in-five rough sleepers reported the use of five drugs or more (20%).**

This is consistent with a study undertaken by Houghton and Hickey (2001) in a study examining the needs, circumstances and service use of a sample of long-term homeless which found that almost half of those interviewed were using more than one illicit drug. In this regard, it substantiates other national and international research which has indicated that homeless individuals, especially rough sleepers, engage in high-risk drug-using patterns, such as polydrug use. Treatment programmes may not always be designed to address polydrug-using practices of clients, often classifying their use in regards to their primary drug of use (EMCDDA, 2000). The evidence of polydrug use in fatal overdose has been highlighted by (Byrne, 2002) and homeless polydrug users are at increased risk as their practices are often influenced by factors such as 'haste', 'isolation' and 'fear of detection' (Henkel, 1999; Ryan, 2002).

- **Dublin had the highest percentage of current illicit drug users (59%). Findings revealed a 30% current heroin prevalence rate among the Dublin homeless sample. This is in comparison to only very limited current use in Galway and Limerick and no use among the Cork sample.**

This is substantially higher than the figures by Holohan (1997), Condon (2001) and Feeney *et al.* (2000) who reported use of an illegal drug. The current heroin prevalence rates further affirm the notion that opiates are not only largely Dublin based within the general drug using population but also within the homeless drug-using population.

- **Over a quarter of respondents in this study had used sedatives (26%). Over a quarter reported current use of sedatives (n=90; 26%), almost a fifth reported anti-depressants (n=68; 19%) and tranquillisers (n=58; 16%). Use of tranquillisers and anti-depressants were also higher among B&B occupants than was observed among hostel dwellers or rough sleepers.**

The use of sedatives/tranquillisers and antidepressants among the homeless population is more than 6 times that found among the general Irish population (3.9) (NACD and DAIRU, 2003). The high level of use among those staying in B&B accommodation is not surprising given the high proportion of women which access such services (Houghton and Hickey, 2000). Smith *et al.* (2001) in a study of homeless women found a high level of misuse of prescribed medications (i.e. using

more than the prescribed dose). International studies have estimated that women's use of psychotropic drugs exceed that of their male drug-using counterparts. For example, the use of medicines such as benzodiazepines is more common among women than men and the difference increases with age (EMCDDA, 2000).

- **Nearly one-in-two hostel dwellers in Dublin reported current use of an illicit drug (48%), while over two-thirds (n=44; 69%) of B&B residents were current illicit drug users.**

This is high in comparison to a study by Feeney *et al.* (2000) in which over a third of the hostel dwelling sample had engaged in illicit use of at least one drug in the previous year with this figure increasing to three-quarters of the 18-34 age group.

- **Higher rates of current heroin (34%), cocaine (25%) and crack use (7%) were found among those sleeping rough than among either hostel dwellers or B&B occupants. This finding was also consistent within the Dublin sample.**

The proportion of rough sleepers who had used any of these drugs is lower than findings from UK research. Fountain and Howes (2002), in a study of drug use among rough sleepers in London, cited that almost half had used heroin and/or crack (47%) with high daily or nearly daily frequency. However, the high rates of current drug use among rough sleepers re-emphasise the need for a range of support around their drug/alcohol use. Debate exists regarding balance between harm minimisation which helps rough sleepers to manage their drug use as part of moving off the streets, and on the other hand, treatment and rehabilitation.

- **Less than a fifth of the total study population reported current methadone use (18%). No current methadone use was found among homeless individuals outside of Dublin.**

The drug treatment data from the Health Research Board clearly indicate that drug use, in particular heroin use, is primarily an urban problem. While recognising that opiate use is largely an urban problem, research has also illustrated that it is highly scattered and localised, with distinct regional variations. Methadone is currently the most widely used treatment modality for opiate dependence in Ireland. The numbers of individuals registered centrally who are in receipt of methadone treatment has continued to increase over the last few years, (from 2,859 in Dec 1997 to 5,865 in Dec 2001), to more than 7,000 in 2004.

- **Over a third of the total study population reported having ever injected (35%) increasing to almost half within the Dublin sample (46%). Nineteen percent of the total study population reported injecting heroin in the last month, all of whom were from the Dublin sample (27%).**

Lifetime prevalence figures for intravenous drug use are considerably higher than those reported by Feeney *et al.* (2000) and Condon *et al.* (2001), documenting rates of 12% and 24% respectively. However higher rates (39%) were found among homeless women in Dublin (Smith *et al.*, 2001) than were observed within this study. Corr (2003c), in a study on the information and advice facility located within the homeless resource service of Merchants Quay Ireland, found that the vast majority of those who had used drugs also reported having injected drugs at some point during their drug-using careers. A possible explanation provided was that many of the clients interviewed were also attendees of the syringe exchange provided by Merchants Quay Ireland. Fountain and Howes (2001) in a UK study on rough sleeping found that 40% of the rough-sleeping sample had ever injected a drug.

- **A third of the total study population scored as problematic drug users (36%). Over two-fifths of the Dublin sample scored as problematic in comparison to less than a fifth outside Dublin (43% v 19%). Almost one-in-two rough sleepers reported problematic drug use (46%).**

The proportion of rough sleepers who scored as problematic is far higher than UK research has indicated. Randall (1998), in a review of the literature on rough sleeping, found that surveys consistently reported around one-in-five of rough sleepers had drug problems. Older rough sleepers tend to have alcohol problems, while younger rough sleepers use drugs (Randall and Brown, 1999b).

- **Problematic drug users were significantly more likely to be younger and report their first homeless episode at a younger age than their non-problematic drug using counterparts and the overall study population.**

Ireland is one of the countries continually reporting to the European Monitoring Centre for Drug and Drug Addiction increases in heroin use by new groups of young people (EMCDDA, 2000).

- **Thirty-three percent of those who reported they used drugs within the Galway sample scored as problematic, which represents 14% of the overall Galway homeless population.**

This is slightly lower, but nevertheless consistent with, the finding by Hourigan and Evans (2003) in a study among sixty-five individuals accessing voluntary services in Galway and Mayo. In their study, of those who were current drug users, 35% of the study sample scored over 6 indicating the need for intensive assessment.

- **Thirty percent of the Dublin sample indicated a high degree of psychological dependence on the drugs currently used. B&B occupants scored the highest level of dependence (36%) within the total study population, followed closely by rough sleepers (30%).**

Feeney *et al.* (2000) found that approximately half of the male hostel dwellers in the 18-34 age group were dependent drug users. Dependence was most common for cannabis (14%). However, almost two-thirds of those who reported ever using heroin were dependent users. The definition of dependent use employed by Feeney *et al.* (2000) was if an individual had taken a drug every day for two weeks or more in the previous 12 months. Smith *et al.* (2001), in a study on homeless women in Dublin, illustrated that a higher percentage of hostel-dwelling women were drug dependent in comparison to those in B&B accommodation. In Glasgow, 7% of 188 male hostel residents were dependent on both opiates and stimulants (Kershaw *et al.*, 2000). Using a different screening instrument (CAGE), Fountain and Howes (2001), in a sample of rough sleepers, found that 80% scored as dependent on the main substance they had used. It is not possible to similarly ascertain the degree of dependence on primary drug use among this study sample as individuals were not asked to state their primary drug.

- **The majority of those experiencing homelessness first used drugs before becoming homeless (87%).**

The relationship between drug use and homelessness is well established in the literature (Kennedy *et al.*, 2001). However, this finding provides additional information on the association between drug use and homelessness within an Irish context.

- **All accommodation providers interviewed operated a “no drugs” policy although some did accept homeless drug users if they complied with the rules and regulations. Staff awareness of respondents’ drug-using status was lower than awareness relating to their current alcohol status in all city locations, with the exception of Cork. Almost a third of current drug users staying in emergency accommodation reported difficulties accessing such services due to their drug use (30%). The stigma associated with being a drug user was the most commonly cited difficulty.**

UK research has indicated that those dependent on drugs and alcohol are more likely to have been excluded than those not dependent (Fountain and Howes, 2001). Homeless people who use drugs have frequently been excluded from provision by virtue of their drug-using status, injecting practices, possession of drugs/injecting equipment (Flemen 1999; Howley and Costello, 2001). Flemen (1999:9) argues that employing a ‘blanket’ policy for all drug users does not differentiate between different patterns and levels of drug use or the types of drugs used. The fact that current or past drug use may represent a barrier to immediate or future accommodation needs, means that it encourages individuals to deny substance problems and enter services with their problems undetected (Hammersley and Pearl, 1997 cited in Flemen 1999). Organisations are concerned about the legal aspects of working with drug users, however, best practice recommends the application of a series of graded sanctions with permanent exclusion from services only employed as a last resort (Flemen, 1999). The involvement of the service user in the development of organisation policies can be highly effective (Britton and Pamneja, 2000). This can help convey a positive attitude within the wider user group as agreement is further enhanced by the fact that their peers have been involved in the decision process (Knight and Honor, 2002). It is also important that the staff feel competent in the use of organisational drug policy (Britton and Pamneja, 2000).

- **Changes in drug-using patterns as a result of becoming homeless were reported by over three-in-four current users (77%). Initiation into drug use, changes in primary drug and routes of administration, increased frequency/quantity, and associated lifestyle behaviour changes were cited.**

Fountain and Howes (2001) found that the majority of rough sleepers only started using drugs upon becoming homeless. For example, almost three-quarters had not used crack cocaine and over half had not used heroin until they became homeless.

Chapter Seven

Risk Behaviour and Health

7.1 Introduction

Drug use can be associated with a number of health consequences and presents an important challenge to public health professionals and medical services alike. This chapter examines the extent and nature of risk behaviours and health complaints among members of the drug-using homeless population.

7.2 Route of Administration Over Past Month

Current users (i.e. licit or illicit use within the last four weeks) were asked their main route of drug administration. Overall, 19% of the homeless population surveyed reported injecting in the last month (n=66). All current injectors were from the Dublin sample (27%).

As highlighted in the previous chapter, over half of current heroin users were daily users (n=40; 52%). In terms of current heroin use, the majority (n=57; 74%) also reported injecting intravenously and one respondent reported injecting intramuscularly. In other words, 16% of the homeless population surveyed reported injecting heroin in the last month. In addition, three current heroin users reported 'skin-popping'⁶¹ as their main route (4%). Over one-in-five of current heroin users reported smoking as their main route of administration (n=16; 21%) which represents 5% of the homeless population. Almost two-thirds of current cocaine users (n=34; 63%) reported injecting the drug. Current users, although in the minority, also reported injecting various tablets, for example, sedatives (n=6), anti-depressants (n=1), tranquillisers (n=1) and steroids (n=1).

Smoking was the main route of administration reported by current users of cannabis and crack, while ingesting was the main route reported by current users of sedatives, anti-depressants, methadone, ecstasy, tranquillisers, hallucinogens, steroids, other opiates and other drugs. In terms of current amphetamine use, 50% (n=4) reported ingesting and the remaining 50% (n=4) reported sniffing.

7.3 Current Injecting Behaviour and Practices

Much of the trouble associated with the use of illicit drugs, such as heroin, comes not from the direct effect of the drug, but rather the circumstances surrounding its use (Hamilton, 2001). In this regard, it was important to include various questions which would examine the injecting practices of homeless individuals. As outlined above, 19% of the total study population reported current IV drug use (n=66), all of whom were from the Dublin sample.

7.3.1 Place of Injecting

Current injectors were asked in some detail about their injecting behaviour (n=66). Firstly they were asked where they usually injected. Table 7.1 illustrates that almost a third of current injectors usually injected at their place of residence (n=19; 32%). Others reported injecting in various public places; park (n=9; 15%), street (n=7; 12%), public toilets (n=4; 7%) or "anywhere" (n=6; 9%).

Analysis revealed that female injectors were significantly more likely to report injecting within their place of residence than their male injecting counterparts ($\chi^2=6.89; df=1; p<0.01$). Sixty-three percent of female injectors reported that they usually inject at place of residence, compared with 37% of the male respondents. Further analysis revealed that the respondent's current accommodation type was related

61 "Skin-popping" refers to an injection between skin and fat layers. Also called "subcutaneous" or "sub-Q" it is injecting the drug just beneath the skin.

to whether clients reported injecting at their place of residence. Sixty-eight percent of those who reported injecting in their place of residence were B&B occupants (n=13), while 21% were staying in a hostel (n=4), and two respondents were staying, one with friends or relatives, and one in a squat (5.5% respectively).

Table 7.1 Place of Injecting by Gender

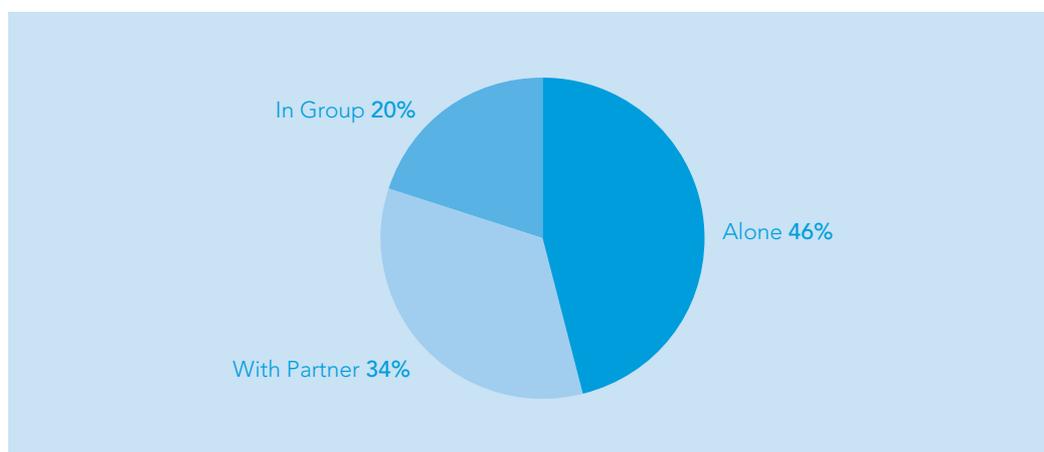
Place of Injecting	Male		Female		Total	
	%	n	%	n	%	n
Place of Residence	19.5	[7]	52	[12]	32	[19]
Park	19.5	[7]	9	[2]	15	[9]
Street	14	[5]	9	[2]	12	[7]
Anywhere	14	[5]	4	[1]	9	[6]
Public Toilet	8	[3]	4	[1]	7	[4]
Home of Friends/Relatives	3	[1]	9	[2]	5	[3]
Other*	22	[8]	13	[3]	20	[11]
Missing		[5]		[2]		[7]

* "Other" place of injecting refers to; squats (n=3), car (n=2), behind church (n=2), phone booth (n=1), waste ground (n=1), canal (n=1), not specified (n=1).

7.3.2 Injecting Company

All respondents were asked with whom they usually injected. Figure 7.1 illustrates that nearly half the respondents reported that they inject alone (n=28; 46%), 34% reported that normally they inject with partner (n=21), and 20% (n=12) reported they are usually in a group when they inject. Analysis revealed that male respondents were significantly more likely to report injecting alone than their female drug injectors ($\chi^2=6.96; df=1; p<0.01$). Sixty percent of male injectors (n=22) reported injecting alone in comparison to 25% of female injectors (n=6). There were no significant differences in injecting habits across categories of accommodation.

Figure 7.1 Injecting Company



Current injectors were also asked whether they usually inject themselves (as opposed to being injected by another person). Table 7.2 shows that just over three-in-four of current injectors reported always injecting themselves (n=50; 76%). However, 15% (n=10) also reported never injecting themselves. This was highly gendered with 36% of female injectors (n=9) reporting not injecting self in comparison to only one member (2%) of the male population of injectors. Female injectors were significantly less likely to report injecting themselves ($\chi^2=13.61$; $df=1$; $p<0.001$). Analysis revealed, although not significant, those that injected themselves were older than those that never injected themselves (mean age of 28 years v 25 years).

Table 7.2 Inject Self by Gender

Inject Self	Male		Female		Total	
	%	n	%	n	%	n
Always	93	[38]	48	[12]	76	[50]
Sometimes	5	[2]	16	[4]	9	[6]
Never	2	[1]	36	[9]	15	[10]
Total	100	[41]	100	[25]	100	[66]

7.3.3 Levels of Risk Behaviour

Current injectors were firstly asked to state at what part of the body they currently inject. This was to ascertain whether individuals were injecting in any particularly dangerous sites. Table 7.3, illustrates that the majority of current injectors reported injecting in the arm (n=37; 57%), while almost one-in-four reported injecting in the groin which is cause for concern as it can increase the occurrence of blood clots (n=14; 22%). Arms and hands were also reported as an injecting site by 7 injectors (11%). Other areas reported included; leg, hand, feet, shoulder and neck.

Table 7.3 Injecting Sites

Injecting Site	Current Injectors	
	%	n
Arm	57	[37]
Groin	22	[14]
Arm and Hand	11	[7]
Leg	3	[2]
Hand	3	[2]
Other*	4	[3]
Total	100	[65]
Missing		[1]

* "Other" injecting site refers to feet (n=1), shoulder (n=1) and neck (n=1)

Regarding injecting risk behaviour, all injectors were asked about the sharing of injecting equipment in the four weeks prior to interview. Table 7.4 below illustrates that over half of current injectors reported the recent sharing of injecting paraphernalia, that is spoons and filters (n=35; 53%). Almost one-in-four current injectors reported lending injecting equipment while rates for borrowing were lower at 17%

(n=11). Analysis revealed that current injectors were significantly more likely to report lending used injecting equipment rather than borrowing others equipment ($\chi^2=12.58$;df=1;p<0.01).

Table 7.4 Current Sharing Behaviour by Gender

Current Sharing Behaviour*	Male		Female		Total	
	%	n	%	n	%	n
Shared IV Paraphernalia	54	[22]	52	[13]	53	[35]
Lent Used IV Equipment	27	[11]	16	[4]	23	[15]
Borrowed used IV Equipment	17	[7]	16	[4]	17	[11]

*Refers to behaviour four weeks prior to administration of survey questionnaire.

Multiple responses allowed.

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 and borrowing others' injecting equipment.

Further analysis revealed that there was no significant difference in reported injecting risk behaviour across categories of accommodation. However, rough sleepers were proportionally more likely to report borrowing others' injecting equipment than individuals staying in either B&B or hostel accommodation. Forty-six percent of injecting rough sleepers (n=5) reported borrowing used injecting equipment in comparison to only 27% (n=3) of B&B occupants and 9% (n=1) of hostel dwellers.

Another measure to determine the intensity of sharing injecting equipment was employed by asking current injectors "how often had they used a needle after someone else had used it". Seventy-eight percent (n=47) said "never". Of those who did report reusing a needle the most common reported frequency was "once" (n=7). However, 3 injectors reported twice, and one injector each reporting 3-5 times, 6-10 times and more than 10 times.

7.3.4 Injecting Difficulties

All injectors were asked whether they had ever experienced any injecting difficulties. Figure 7.2 shows that of the 66 current injectors, only 17 reported never having experienced an injecting-related difficulty (26%). Male injectors were significantly more likely to report having "never" experienced injecting difficulties in comparison to their female injecting counterparts ($\chi^2=3.98$;df=1;p<0.05). Thirty-four percent (n=14) of male injectors reported no difficulties as opposed to 12% (n=3) of the female current injecting population.

Figure 7.2 Ever Experienced Injecting Difficulties

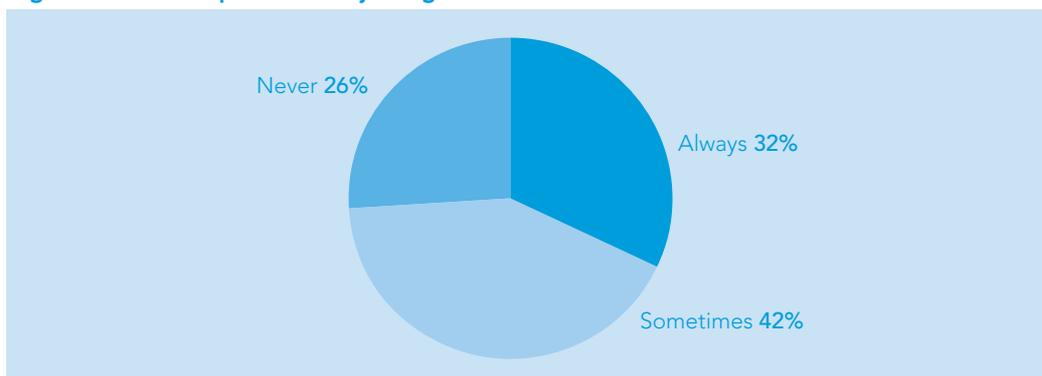


Table 7.5 illustrates the experience of various injecting difficulties reported by current injectors within the last three months. Almost three-quarters of current injectors reported scarring or bruising of the injecting site (n=47; 71%), while nearly two-thirds reported difficulty injecting (n=42; 64%). Although not significant, female injectors were proportionally more likely to report scarring/bruising of injecting site than their male counterparts (71% v 57%).

Table 7.5 Injecting Difficulties within the Past Three Months

Injecting Difficulties	Current Injectors	
	%	n
Scarring/Bruising	71	[47]
Difficulty Injecting	64	[42]
Dirty Hit	36	[24]
Abscesses/Infections	32	[21]
Accidental Overdose	20	[13]

Only two-thirds (n=24, 36%) of injectors reported having a 'dirty hit'⁶² with almost one-in-three reporting the experience of abscesses or infection in the three months prior to interview (n=21; 32%). Finally, one-in-five of injectors reported accidental overdose (n=13; 20%). Male injectors accounted for 69% of those who reported an accidental overdose in the last three months.

7.3.5 Overview of Injecting Risk Behaviour

Table 7.6 provides an overview of injecting risk behaviour practices among the cohort of homeless injectors. As conveyed below, a range of factors can contribute towards injecting risk behaviour and were commonplace among homeless injectors. Practical issues, such as not having appropriate and safe storage facilities for clean injecting equipment when experiencing homelessness, were reported as influencing risk behaviour. One individual equated his situation to that of "a tortoise", in having "to carry the load on his back".

Table 7.6 Overview of Injecting Risk Behaviour

Variable	Current Injectors
	(n=66)
	%
Difficulties Injecting	74
Polydrug Use	63
Street Injectors	54
Shared IV Paraphernalia	53
Inject Alone	46
Never/Sometimes Inject Self	24
Lent Used IV Equipment	23
Accidental Overdosed	20
Borrowed Used Equipment	17

62 Dirt, bacteria, fungi and other micro-organisms in and on your needle can cause bends (a dirty hit).

7.4 Drug Use and Homelessness: Changes in Behaviour and Practices

7.4.1 Changes in Drug Use

Over three-quarters of current users (n=156; 77%) reported that their drug use had changed since they had become homeless. Changes reported had less to do with people starting to use when they become homeless, and were more often associated with drug-using practices and behaviour becoming more 'risky'. Figure 7.3 below presents some of the comments made by respondents. These comments highlight the diversity of behaviour changes, ranging from changes in primary drug and routes of administration, to increased frequency/quantity, and to associated lifestyle behaviour changes (criminal activities, street work). However, the themes highlighted cannot be generalised to the total drug-using population.

Figure 7.3 Negative Changes in Patterns of Drug Use as a Result of Being "Out of Home"

I use more drugs when on the streets, as there's nowhere to put your head down and you're looking for money to buy drugs 24/7. I mostly use heroin when on the streets. If I have enough money then I would buy a bit of cocaine.

(Male, 33 years)

I am using a wider selection of drugs since being homeless. I am using different drugs at the same time, greater access to drugs as they are easier to get.

(Male, 25 years)

At home I was only smoking hash. Since I became homeless, I started using heroin.

(Male, 40 years)

It got worse. I would take anything especially at night because it would be so cold and if it's wet, you'll take anything to knock yourself out, so you can sleep through the night.

(Male, 46 years)

First it was only cannabis and drink. Then I was introduced to heroin and started using it... I stayed off the drugs for six months and I just couldn't cope. They should give us free heroin. I'm a long-term user.

(Male, 32 years)

I was looking for something to keep me comfortable. So I was taking gear to keep me warm, when I was hungry and when I was lonely.

(Male, 23 years)

It's gone up a lot – there's nothing else to do when you are on the streets. I had never touched heroin in my life until I came on the streets. One day someone will probably hand me a spike.

(Male, 20 years)

Continues over page

It got worse, then I started selling heroin. I sold my body for drugs, I lost weight from not eating, I shoplifted.

(Female, 28 years)

I went up, down, sideways, everywhere. I used everything. I jumped from one drug to another. I tried to stop using and picked up the drink, then got a taste for heroin.

(Male, 28 years)

I've seen a lot of people do worse things than if you go home to your normal home. When you're homeless, you're exposed to a lot more.

(Female, 26 years)

Since homeless I became an alcoholic, now I'm a junkie.

(Male, 35 years)

It is important to note that, although limited in comparison to the negative aspects above, there were also various positive changes reported by respondents. As conveyed within Figure 7.4 below, some homeless individuals stated that having become homeless, their drug-using patterns or behaviour had changed in a positive direction. However, these responses were in the minority and as such would not be representative of the total study population.

Figure 7.4 Positive Changes in Patterns of Drug Use as a Result of Being Homeless

I have cut down a lot. The price of drugs in Ireland is too much.

(Female, 41 years)

My use has ceased except for cannabis. I am using much less drugs since I left home. My father was using drugs, so I needed to get out of the environment.

(Male, 26 years)

I don't really smoke much at all, I smoke less since being on the streets.

(Male, 30 years)

I was in a different environment. Staff were willing to help me and I changed for the better... meals were there, being able to take a walk and come back, it all helped me stop. My methadone dose reduced from 120 to 40 mls since becoming homeless.

(Male, 46 years)

I don't use as much because you can't afford it.

(Female, 19 years)

My drug use got better since coming to the hostel, it opened my eyes not to do heroin.

(Female, 19 years)

7.4.2 Changes in Injecting Behaviour

In addition, individuals who had injected in the last four weeks were asked whether they believed that their injecting practices had changed in any way since they first became homeless. Over two-thirds of current injectors (n=44; 69%) reported that their injecting practices had changed since being homeless. The majority stated that they were using different types of drugs, greater quantities, using more frequently and less safely. A number of individuals also reported that they only commenced their injecting behaviour upon becoming homeless. The following quote by a female current injector highlights, as an example, this initiation into injecting;

Because you are homeless you try to get more value for money, you buy two bags between three, because I was a smoker I'd use more so instead you'd cook it all up together and split it between us...that's how I started injecting.

(Female, 29 years)

Figure 7.5 below presents a selection of quotes from homeless current injectors which illustrate more explicitly the manner in which their injecting behaviour has changed since becoming homeless.

Figure 7.5 Changes in Injecting Practices as a Result of Being Homeless

I used more and took more chances. I shared needles with people with HIV through sleeping rough. It's a miracle that I am HIV negative.

(Male, 47 years)

It has become less hygienic. The discomfort of not having somewhere to go makes the hit not last as long.

(Male, 40 years)

I only started when I became homeless.

(Female, 21 years)

It got rampant, I wouldn't have injected all the time before I became homeless, but since I became homeless, it's become a full-time gig.

(Male, 23 years)

I started using my neck for injecting.

(Female, 26 years)

It's harder to get an injecting site as it is so cold on the streets.

(Female, 23 years)

I inject more often. I inject tablets in the park.

(Female, 20 years)

7.5 Physical Health

7.5.1 Physical Health Complaints

All respondents were asked to report whether they were currently suffering from any of the listed health complaints. Table 7.7 below outlines the reported levels of physical complaints among both the total study population (n=355) and problematic users (n=127). The problematic drug users reported higher levels of physical complaints with the exception of the following; blood pressure, eye and ear, epilepsy and diabetes. Rates for these complaints were only marginally higher among the total study population. Just over two-fifths of the total study population reported dental issues (43%) in comparison to almost two-thirds of problematic drug users (62%). Ninety percent of both the total population and problematic drug-using group reported suffering from one or more physical complaints.

Over a quarter of the total population (n= 100; 28%) were suffering from 5 or more complaints in comparison to over a third of problematic drug users (n=47; 37%). A difference was also noted in the mean number of conditions reported. The mean number for the total study population was 3 (range: 0-15) in comparison to 5 complaints for the problematic drug users (range: 0-15).

In terms of experience of physical health complaints by homeless accommodation type, rough sleepers reported a slightly higher mean number of complaints (mean=4) than those staying in hostel accommodation and B&B (mean=3 complaints). However, problematic drug users staying in B&B accommodation reported a higher mean number of complaints (mean = 6 complaints) than rough sleepers (5 complaints) or hostel dwellers (4 complaints).

Table 7.7 Physical Health Complaints

Physical Health Complaints	Total Study Population		Problematic Drug Users	
	%	n	%	n
Headache	49	[173]	54	[69]
Bones & Joints	44	[155]	48	[61]
Dental	43	[154]	62	[79]
Eye and Ear	31.5	[112]	31	[40]
Foot	25	[88]	27	[34]
Asthma	25	[89]	31	[40]
Skin	19	[66]	20	[26]
High Blood Pressure	17.5	[62]	16	[20]
Bronchitis	16	[57]	21	[27]
Peptic Ulcer Disease	14	[50]	16	[20]
Other ^{63,64}	13	[45]	9	[12]
Urinary Tract	10	[35]	13	[17]
Epilepsy	8	[27]	9	[11]
Heart Disease	7	[26]	6	[8]
Gastro-Intestinal Tract	7	[26]	10	[13]
Rheumatic Disease	6.5	[23]	8	[10]
Diabetes	3	[11]	3	[4]
Tuberculosis	2	[8]	2	[3]

*Multiple responses were allowed

7.5.2 Medical Card

Respondents were also asked if they had a current medical card. Table 7.8 illustrates that nearly two-thirds of the total study population (n=219; 62%) reported being in receipt of a current medical card. The average age of those who had a medical card was 37.2 years, while those who did not have a card had an average age of 31.3 years. This is in comparison to just over half of problematic drug users (n=66; 52%).

63 "Other" physical health complaints refer to low blood pressure (n=4), cancer (n=4), liver disease (n=4), cirrhosis of liver (n=2), constipation (n=2), thyroid (n=2), eczema (n=2), Raynaud's Disease (n=2), lungs (n=2), blood clots (n=2), anaemic (n=1), abscesses (n=1), kidney failure (n=1), physical disability (n=1), blindness (n=1), thick blood (n=1), back problems (n=1), dizzy spells (n=1), ulcer (n=1), heart attack (n=1), seizures (n=1), haemorrhoids (n=1), pneumonia (n=1), high cholesterol (n=1), arthritis (n=1), DVT (n=1), lymphoma (n=1).

64 "Other" physical health complaints refer to anaemia (n=1), lymphoma(n=1), abscesses(n=1), constipation (n=1), heart attacks(n=1), blood clots (n=1), cirrhosis (n=1), thyroid (n=1), eczema(n=1), Raynaud's Disease (n=1), seizures(n=1), not specified (n=1).

Table 7.8 Current Medical Card

Current Medical Card	Total Study Population		Problematic Drug Users	
	%	n	%	n
Yes	62	[219]	52	[66]
No	38	[136]	48	[61]

Findings also revealed that more than one-in-two rough sleepers of the total study population reported having a current medical card (n=32; 58%). Higher rates of current card possession were found among problematic drug users who were sleeping rough (n=18; 69%).

7.6 Blood-borne Infections

7.6.1 Hepatitis B, C Testing and Results

Individuals were asked to state whether or not they had ever been tested for hepatitis B or C. In addition, they were asked whether they had ever received the hepatitis B vaccination. Table 7.9 shows that less than half the respondents (n=170; 48%) reported having ever been tested for hepatitis B, while half (n=175; 50%) reported having ever been tested for hepatitis C. This is in comparison to over four-fifths of the problematic drug-using population.

Table 7.9 Test for Hepatitis B, C

Ever Tested	Total Study Population		Problematic Drug Users	
	%	n	%	n
Hepatitis B	48	[170]	81	[101]
Hepatitis C	50	[175]	82	[102]

Forty percent of respondents (n=135) had received the vaccination for hepatitis B. Table 7.10 shows that in terms of gender distribution, although not significant, female respondents were proportionally more likely to have been vaccinated against hepatitis B than their male counterparts.

Table 7.10 Vaccination for Hepatitis B by Gender

Vaccination Hep B	Total Study Population		Problematic Drug Users	
	%	n	%	n
Male	36	[84]	65	[52]
Female	48	[51]	76	[34]
Total	40	[135]	69	[86]

Individuals were also asked about their current hepatitis B and/or C status. Table 7.11 illustrates the extent to which clients reported being aware of having blood-borne viruses. Among those tested (n=175), nearly one-in-two reported being hepatitis C positive (47%), which represents 23% of the total study population. Ninety percent of those who reported a positive hepatitis C status were from the Dublin sample (n=74), with 5% (n=4) from Galway, and 3% (n=2) from Cork and Limerick respectively. This refers to 21% of the total Dublin homeless population, 11% of the Galway sample and 6% from the Cork and Limerick samples. This is in comparison to a positive status of 64% (n=65) among problematic drug users tested for hepatitis C (n=102), representing 51% of the problematic drug-using sample. Similarly, the majority of those reporting a hepatitis C positive status among the problematic sample were from Dublin.

Analysis revealed that respondents who had ever injected were significantly more likely to be hepatitis C positive ($\chi^2=77.41$;df=1;p<0.001). Sixty percent of those who had ever injected were hepatitis C positive in comparison to only 4% of non-injectors. Furthermore, of those who were hepatitis C positive, the majority were currently users of illicit drugs (87%). Analysis also revealed that there was a significant relationship between having a positive hepatitis C status and current use of an illicit drug ($\chi^2=52.41$;df=1;p<0.001).

Eleven percent of those tested (n=20) within the total study population, and 9% among the problematic drug-using population (n=9) stated that they were unsure of their current status. This could suggest that a substantial number of individuals may not have had their results disclosed to them once tested. Alternatively, it could also be that their status at present is unknown given the length of time which has lapsed since the test was undertaken.

Table 7.11 Results Hepatitis (B and C)

	Total Study Population		Problematic Drug Users	
	%	n	%	n
Hepatitis B (positive)	7	[12]	8	[8]
Hepatitis C (positive)	47	[82]	64	[65]

Furthermore, of the 82 individuals who reported a positive hepatitis C status among the total study population, 13% (n=11) reported currently receiving treatment. A similar level of treatment contact was also reported by the problematic drug-using population (n=7; 11%). The type of treatments cited included; hospital check-ups, vaccinations (interferon), blood tests, liver checks and triple therapy.

Lower numbers reported a positive hepatitis B status. Less than one-in-ten respondents of both the total study and the problematic drug-using population reported a positive hepatitis B status (7% and 8% respectively).

7.6.2 HIV Testing and Results

Over half of the total study population (n=179; 52%) had received a HIV test. This is in comparison to over four-fifths of problematic drug users (n=100; 80%). Problematic drug users reported a shorter mean length of time since last tested than that of the total study population (12 months v 17 months).

Table 7.12 below illustrates that B&B occupants reported higher levels of HIV testing among both the total study and problematic drug-using populations. Over four-fifths of rough sleepers who were problematic drug users had received a HIV test (n=21; 81%).

Table 7.12 HIV Test by Main Accommodation Type

	Total Study Population		Problematic Drug Users	
	%	n	%	n
Hostel	46	[79]	80	[40]
B&B	73	[50]	91	[32]
Rough Sleeping	60	[33]	81	[21]

In terms of HIV status, respondents were provided with the opportunity to volunteer their result. Of those who volunteered their result within the total study population (n=104), 6 individuals reported a positive HIV status and 98 respondents reported a negative status, five of whom were problematic drug users.

7.7 Psychiatric Health

7.7.1 Concerns Regarding Psychiatric Health

Nearly a half of all respondents (n=169; 48%) reported having concerns regarding their psychiatric health with over three-quarters having sought help for these concerns (n=133; 78%). Analysis revealed that those who scored as problematic drinkers were significantly more likely to report experiencing psychiatric concerns than their non-problematic drinking counterparts ($\chi^2=4.06; df=1; p<0.05$).

Although not significant, problematic drug users were also proportionally more likely to report psychiatric health concerns than their non-problematic drug-using counterparts (50% v 40%).

7.7.2 Experience of Psychiatric Services

Three main questions were asked in order to ascertain respondents general mental health status. As Table 7.13 conveys, 42% (n=150) of the total study population had undergone a psychiatric assessment, 30% (n=107) had been admitted to a psychiatric hospital and 30% (n=108) had been diagnosed with a psychiatric illness. Figures were largely similar for the problematic drug-using population.

Table 7.13 Experience of Psychiatric Services

Psychiatric Health	Total Study Population		Problematic Drug Users	
	%	n	%	n
Ever Undergone a Psychiatric Assessment	42	[150]	44	[56]
Ever Admitted to a Psychiatric Hospital	30	[107]	29	[37]
Ever Diagnosed with a Psychiatric Illness	30	[108]	29	[37]

**Multiple responses were allowed*

Of those diagnosed with a psychiatric illness, 70% (n=76) reported that they were currently receiving treatment in comparison to only 60% of problematic drug users (n=22). This relates to 21% of the total study population and 17% of the problematic drug-using population respectively.

More specifically, respondents were asked what type of treatment. Prescribed medication was the most common treatment. Overall, 19% of the study population (n=66) stated that they were currently on prescribed medication for their psychiatric health complaints in comparison to 15% (n=19) of problematic drug users. In terms of gender distribution, a larger proportion of female respondents reported taking prescribed medication for psychiatric health complaints than the male respondents (total study population; 26% v 15%) (problematic drug-using population; 12% v 20%). Other treatment cited included counselling, community psychiatric services and GP.

7.7.3 Psychiatric Health and Accommodation

Figure 7.14 below, illustrates psychiatric experiences by the three main accommodation types; hostel dwellers, rough sleepers and B&B residents.

More hostel dwellers within both population groups reported having ever undergone a psychiatric assessment than those staying in B&B accommodation or sleeping rough. Among the total study population, 35% (n=61) of those staying in hostels reported having been admitted to a psychiatric hospital in the past, in comparison to only 23% (n=13) and 22% (n=15) of rough sleepers and B&B residents respectively. Similar patterns are observed for the problematic drug-using population. Problematic drug-using B&B occupants exceeded hostel dwellers and rough sleepers in terms of ever diagnosed with a psychiatric illness.

Table 7.14 Experience of Psychiatric Services by Main Accommodation Type

Psychiatric Health	Total Study Population			Problematic Drug Users		
	Hostel	B&B	Rough Sleeping	Hostel	B&B	Rough Sleeping
Ever Undergone a Psychiatric Assessment	47	33	39	56	37	38
Ever Admitted to a Psychiatric Hospital	35	22	23	37	23	27
Ever Diagnosed with a Psychiatric Illness	35	30	23	31	34	27

7.8 Psychiatric Health and Drug Use: the Provider Experience

“Dual diagnosis” which is the co-occurrence of drug and/or alcohol use and mental health problems surfaced as the most pressing issue for both homeless and drug service providers in all four cities.

Often the ones that present with mental health problems drink alcohol as well, take methadone and possibly deal in street drugs. They would have mental health issues like schizophrenia, bipolar depression and depression.

(Drug service provider – Dublin)

Anyone working in homeless services is doing dual diagnosis because certain health problems, psychological distress and drug-use go hand in hand.

(Homeless service provider – Limerick)

Mental health is a big issue.

(Accommodation service provider – Dublin)

The mental health thing is probably the biggest concern that I would have.

(Accommodation service provider – Dublin)

While most service providers acknowledged that staff in psychiatric services were working under serious constraints, they stated that it was difficult to refer homeless drug users to psychiatric services, they received little support from psychiatric services to deal with the issue and there was no service which was prepared to deal with drug use and mental health problems simultaneously.

It's unfortunate that we still have psychiatric hospitals which will not dispense methadone at all. Therefore, the patient who is admitted in a suicidal state is out again in 24 hours. That is a simple way for making sure your hospital does not have to deal with the consequences.

(Drug service provider – Dublin)

The response is "when they get their drug problem sorted out, we'll look at them then". So, it is like the chicken and egg situation.

(Drug service provider – Dublin)

7.9 Summary and Conclusions

This chapter has presented an overview of risk behaviour practices among homeless drug injectors and various health issues and concerns for problematic drug users.

Injecting Risk Behaviour:

- **Fifty-four percent of current injectors were street injectors. Males were more likely to report injecting in public than their female counterparts.**

Those who inject in public places are more 'risk oriented' (Klee and Morris, 1995; 839). Safe injecting rooms and hostels for injecting drug users are two harm reduction interventions that are considered particularly appropriate for homeless people. An Australian study found that the introduction of an injecting room addressed the wider community harms associated with homeless drug users injecting in public places (Frey *et al.*, 1999). A feasibility study on the provision of a hostel for homeless drug users in Dublin found that such a facility would enable the use of clean needles, safety from overdose and reduction in street injecting (Costello and Howley, 2000).

- **Almost half of respondents reported that they usually inject alone (46%). Males were significantly more likely to inject alone than their female counterparts.**

Injecting alone is considered a high risk factor for fatal overdose (Ryan, 2002). Self-injectors are usually older and have longer injecting careers (Cox and Lawless, 1999). Female drug users are more likely than male injecting drug users to have a sexual partner who is an injecting drug user (Cox *et al.*, 1999). This can have considerable impact in terms of injecting behaviour and practices as female drug users often seek their assistance due to a reluctance or lack of ability to self inject (Lawless, 2003).

- **Only 26% of current injectors reported not experiencing an injecting-related difficulty within the last three months. Male injectors were significantly more likely to report not having experienced any difficulties. Scarring and bruising of the injecting site was the most commonly reported difficulty (71%). Almost one-in-three reported abscesses or infections of the site (32%), while one-in-five current injectors reported accidental overdose in the three months prior to interview (20%).**

Injecting difficulties are common among drug users in general (Cox and Lawless, 2000). Knowledge on injecting techniques is often acquired when they are injected by others, a behaviour which is learnt by a process of trial and error (Linnell, 2002; 15). Taylor *et al.* (2004), in an ethnographic study which was combined with video footage on injecting practices in Scotland, documented that researchers witnessed 79 unsuccessful attempts to locate a vein. The gender differences highlighted also substantiates other Irish research which has shown that women drug users suffer from more injecting-related complaints than their male counterparts and are more likely to complain of difficulties injecting because of smaller and less visible veins (Geoghegan *et al.*, 1999; Lawless 2003). Homelessness has been identified as a risk factor for overdose among opiate users in particular (EMCDDA, 2002).

- **Over one-in-two current injectors reported sharing injecting paraphernalia in the previous four weeks (53%). Almost one-in-four reported lending injecting equipment (23%) while rates for borrowing were lower at 17%. Injectors were significantly more likely to report lending used injecting equipment rather than borrowing others' equipment.**

Findings from Irish studies have indicated high levels of drug-related risk behaviour especially in the young homeless population (Cox and Lawless, 1999; Costello and Howley, 2000). The above figures are extremely high in view of the 67% and 58% lifetime sharing rates reported by Feeney *et al.* (2000) and Condon *et al.* (2001) respectively. Among homeless women, Smith *et al.* (2001) and Cleary and Prizeman reported that a third had ever shared injecting equipment (33%). Use of drug services among a sample of rough sleepers in London found that 85% of the injectors in the study had used a needle exchange in the last month, while 28% of the respondents who were dependent on heroin and/or had used it daily or almost daily had reported methadone treatment (Fountain and Howes, 2001). Gossop *et al.* (1997) showed that lending of used injecting equipment was more common than borrowing used injecting equipment. Moreover, they found that sharing of injecting paraphernalia, in particular spoons and water containers was twice as common as the sharing of injecting equipment, indicating that IDUs are less discriminatory about the sharing of injecting paraphernalia than is the case for needles and syringes. Harm reduction approaches are particularly pertinent for homeless drug users as they are more likely to share injecting equipment due to having no safe places to store and dispose of needles (Costello and Howley, 2000). Taylor *et al.* (2004:10) suggest that in situations where people are injecting with other injecting drug users, better ways of distinguishing each others' equipment is required.

- **Over two thirds of current injectors (69%) reported that their injecting practices had changed as a result of homelessness.**

In a study of homelessness among drug users, Cox and Lawless (1999) found that 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 while over half reported that their injecting behaviour had changed. Fountain and Howes (2002:11) in a study of rough sleepers in the UK found that four-in-five respondents had started at least using one new drug while homeless. Furthermore, it was found that an increase in drug use was *strongly related to a worsening housing situation*.

Physical Health:

- **Headaches, bones and joints and dental issues were the most commonly cited physical complaints.**

The physical and mental health of homeless people is considerably worse than that of general population (Bines, 1994). These findings are in line with other research undertaken on the health of homeless individuals which show that homeless people are more likely than their housed counterparts to suffer from arthritis, heart disease, tuberculosis, hepatitis C, problems with bones and joints, eye and ear complaints, epilepsy, skin problems and injuries from accidents and assaults (Holohan, 1997; Feeney *et al.*, 2000; Condon *et al.*, 2001). These results are not surprising as a review of literature by Moore *et al.* (1997; 26) found that temporary accommodation can often complicate continuity of care and exacerbate many health issues. Health problems are also associated with low mortality rates as research in the UK has illustrated that the average age of death of those recorded as homeless on coroners' reports varies between 42 and 53 years (Warnes, 2003).

- **Problematic drug users reported higher levels of dental complaints than members of the total study population (62% v 43%).**

Condon (2001) conducted an oral health survey, which included a dental examination, among 234 homeless people in Dublin. She found that 98% of those examined needed dental treatment. This highlights that an individual's perception of personal health and well-being can often be different to their objective health status. Research has indicated that drug users have a significantly higher level of self-assessed oral health problems, with less use of treatment services than non drug users (Sheridan *et al.*, 2001). In a study on dental health access to treatment, Sheridan *et al.* (2001) found that the mean time for all drug users since their last visit to the dentist was twice that of non-drug users.

- **Problematic drug users reported higher rates for the majority of physical health complaints than was found among the total study population. A higher mean number of complaints was also observed (mean; 5 v 3 complaints). Over a third of problematic drug users reported suffering from 5 or more complaints in comparison to over a quarter of the total study population (37% v 28%).**

Homeless people have multiple health problems (Holohan, 1997) while injecting drug users are at most risk of health-related problems (EMCDDA, 2002). Holohan (1997) reported that 66% of homeless people experienced at least one physical or psychiatric problem. In a study on the health status of homeless persons in Galway, Hourigan and Evans (2003) found that 59% of their sample had physical health problems.

- **Problematic drug users staying in B&B accommodation reported a higher mean number of complaints than problematic rough sleepers or hostel dwellers.**

The majority of those using B&B accommodation in Dublin are women with children (Houghton and Hickey, 2000; Smith *et al.*, 2001). Research has indicated that female drug users experience a greater number of health complaints than their male drug using counterparts (Geoghegan *et al.*, 1999).

- **Problematic drug users were proportionally less likely than members of the study population to report a current medical card (51% v 64%).**

These findings nevertheless reflect general medical card possession rates among homeless people. For example, a profile of outreach service users in 2002 by the Dublin Simon Community reported that just over a half (54%) had a medical card (Dublin Simon Community, 2003). Similar figures were

found by Holohan (1997). Findings also revealed higher rates of current medical card possession among drug users who were sleeping rough than the general rough sleeping population (69% v 58%). However, Lawless (2003) in a study of the health status of female drug users, found that individuals tended to report having a medical card when in actual fact it had expired.

Blood-Borne Infections:

- **Over half of problematic drug users were hepatitis C positive (51%) compared to 23% of the total study population. Individuals who had ever injected were also significantly more likely to be hepatitis C positive.**

Condon *et al.* (2001) found that screening positive for hepatitis C was significantly associated with the use of IV drugs and being a rough sleeper. Of those tested, 18% tested positive for hepatitis C. Smith *et al.* (2001) found that a quarter of homeless women had tested positive for hepatitis C, of whom the majority was not receiving treatment (80%). Some research suggests that HCV infection is associated with duration of injecting, with lower prevalence rates found among young recent onset injectors (Crofts *et al.*, 1993; Loxley *et al.*, 1997). Irish harm reduction interventions have been criticised for concentrating on reducing unsafe injecting practices but not succeeding in reducing risk factors associated with Hepatitis C (Smyth *et al.*, 1998).

- **Higher rates of hepatitis B vaccination were found among problematic drug users than the total study population (69% v 40%). Female respondents were proportionally more likely to have received the hepatitis B vaccination than their male counterparts.**

Levels of hepatitis B vaccination for the total study population are consistent with those found by Corr (2003a) in which 47% of the sample under investigation had been vaccinated against hepatitis B with female clients being more likely to have been vaccinated compared to their male counterparts.

Psychiatric Health and Well-Being:

- **Nearly one-in-two of the study population reported having concerns about their psychiatric health. Less than half of the respondents reported having undergone a psychiatric assessment (42%), while less than a third have been admitted to a psychiatric hospital (n=30%), or have been diagnosed with a psychiatric illness (n=30%).**

These findings again substantiate other research which conveys that a high proportion of homeless people have psychiatric health complaints (Holohan, 1997; McKeown, 1999; Feeney *et al.*, 2000; Crowley, 2003). High rates of depression have been reported as one of the main psychiatric complaints among the homeless population (Holohan, 1997; Cleary and Prizeman, 1998; Feeney *et al.*, 2000; Hourigan and Evans, 2003).

- **Problematic drinkers were significantly more likely to report having psychiatric concerns than their non-problematic drinking counterparts. While not significant, problematic drug users were proportionally more likely to report psychiatric health concerns than their non-problematic drug-using counterparts.**

The co-occurrence of drug and/or alcohol use and mental health problems, referred to as "dual diagnosis", is an issue of concern for the homeless population and service providers alike. Among a group of residents in cold weather shelters in London, 38% of the sample had a 'dual diagnosis' (O'Leary, 1997). It is estimated in the UK that a half of clients in drug and alcohol services also have mental health problems (Alcohol Concern, 2002). Dual diagnosis can lead to loss of

accommodation, behavioural problems and an unwillingness to co-operate with services (O'Leary, 1997). However, Manley (1998) argues that in practice individuals rarely receive a formal diagnosis, so the term is often simply used to demonstrate individuals who present with both alcohol/drugs and mental issues. Many tend to fall through the system without being treated by drug services or psychiatric services. Norden (2001:16) refers to concurrent mental illness and problematic drug and/or alcohol use as "ping pong" therapy whereby *service systems and agencies maintain, rather than modify, existing services and will refer those on who do not meet strict programme criteria.*

- **Prescribed medication was the most common psychiatric treatment cited. Female respondents were proportionally more likely to report prescribed medication than their male counterparts.** This is consistent with findings from other studies which have highlighted that within the homeless population, females are more likely to report and seek treatment for psychiatric complaints (Smith *et al.*, 2000).

- **Results found that more hostel dwellers reported having ever undergone a psychiatric assessment or having ever been admitted to a psychiatric hospital. This was consistent for the total study and problematic drug using population. However, B&B occupants exceeded hostel dwellers and rough sleepers in terms of ever diagnosed with a psychiatric illness.**

Hostels are often employed as a main accommodation option for psychiatric services. As Fernandez (1996: 215) states *many long-term homeless mentally ill are forced to resort to emergency social accommodation for their permanent abode* (cited in McKeown, 1999). Although it is believed that mental illness is most common among people sleeping rough (Anderson *et al.*, 1993), it is often the case that the mental health problems of street homeless clients will not be diagnosed (O'Leary, 1997). UK research has found that experience of mental health problems are eight times higher among hostel and B&B residents and eleven times as high among people sleeping rough compared to the general population. One-in-four single homeless people with mental health problems had been in a psychiatric hospital at some time in the past (Bines, 1994).

Chapter Eight

Service Provision

8.1 Introduction

This chapter focuses on issues regarding service provision and practice. Levels of contact with homeless, drugs and generic services are illustrated in addition to presenting suggestions for improvements. A self-reported analysis of related service needs is also conveyed. More specifically, the aim of the chapter is to highlight issues which may be of concern in the provision and delivery of services to meet the needs of the drug-using homeless population. In this regard, barriers towards accessing services, adequacy of existing services provided for homeless drug users and the overall capacity of organisations to work with homeless drug users will be examined.

8.2 Homeless Services

8.2.1 Contact with Homeless Services

All respondents were asked about their contact with various homeless services in the three months prior to the interview. Over two-thirds of the total study population (n=243; 69%) reported contact with emergency accommodation services within the specified time period. This is not surprising given that a half of the total study population were living in hostels (n=175; 50%) and a further 19% (n=69) were staying in B&B accommodation. There were also high levels of contact with drop-in centres (n=160; 45%) and food services (n=154; 43%). Contact with the Homeless Persons Unit was reported by nearly a third of respondents (n=114; 32%), while over a quarter were in contact with street outreach services (n=100; 28%). Contact with transitional, settlement and day services were reported by 15% (n=54), 14% (n=48) and 13% (n=45) respectively. Fourteen individuals (4%) also reported contact with the multi-disciplinary team within the three months prior to interview⁶⁵.

8.2.2 Factors Influencing Use of Homeless Services

All participants were also asked to state what attracts them to using particular homeless services. Multiple responses were allowed. Food was the most commonly reported reason (n=59; 17%), followed by staff of the service (n=57; 16%). Over one-in-ten of the respondents (n=47; 13%) stated that services were just merely "somewhere to go" and that they had no other options available to them. Other responses included; advice/information, company, service environment (familiarity/convenience) and specific service features (e.g. opening hours, cost etc.).

In terms of the specific remit of this study, very few respondents cited the absence of drug/alcohol users as a factor influencing use of homeless services. Only 3% (n=12) of responses stated no drug users or injectors would be a factor, whereas the absence of alcohol users was noted by only 4 individuals (1%). The following quotes from members of the non-drug-using homeless population demonstrate how drug and alcohol use among service users can influence the use of homeless services.

I will avoid some hostels because of drug users. I have a fear of needles.

(Male, 48 years)

The service is good but drug addicts are running it now. You can't relax. They take money off you. I can't use the pool table, cos they push you out of the way.

(Male, 24 years)

⁶⁵ It is likely that levels of contact with the multi-disciplinary team are an underestimate. Respondents may have been in contact with a worker but were unaware that they worked for the multi-disciplinary team.

It is dear but it's clean, tidy and you have your own room and nobody is on drugs. I don't like a hostel cos something triggers in my head to get a bag of needles. When I'm there someone always gives you needles so I stay away from there to keep clean.

(Male, 46 years)

8.2.3 Difficulties Accessing Homeless Services

Just over a third of respondents reported having ever being refused access to homeless services (n=121; 34%). Almost one-in-two of problematic drug users reported being refused access to homeless services (48%), in comparison to over a third for problematic drinkers (38%). Problematic drug users reported that they were usually refused access to homeless services as a result of the use and supply of drugs on the premises. Figure 8.1 presents different reasons provided by respondents in terms of refusal from homeless services due to drug and alcohol issues.

Figure 8.1 Refusal of Access to Homeless Services (Drugs/Alcohol Issues)

I passed on a lighter to someone who went into the toilets. He came out stoned so they must of thought I gave him drugs.

(Male, 27 years)

I was caught injecting and then was barred.

(Male, 21 years)

I was barred from [service]- They tried to say I was using in the toilet but I wasn't.

(Male, 23 years)

I was barred for goofing off [...] also barred for selling tablets.

(Male, 23 years)

A higher percentage reported difficulties accessing homeless services (42%), than refusal to services although over half of the respondents reported that they had not experienced any difficulties (n=206; 58%). However, over one-in-two problematic drug users reported difficulties accessing homeless services (52%) in comparison to 47% of problematic drinkers. Among those who reported difficulties, common issues reported included; free phone service (length waiting/continuously engaged, no vacancies), finding it hard to get appointments, accommodation for couples, services not answering phones, rules and regulations, lack of vacancies and problems around system benefits and allowances. The impact of drug use and psychiatric health issues on access to homeless services, although in the minority, were also noted among respondents, as illustrated by the following quotes:

I have to attend the methadone clinic and no matter what I can't make it back up to [a homeless service] before it closes and it only opens those hours each day.

(Male, 25 years)

Due to the fact that I suffer from psychiatric problems, I fall through the cracks as different services are not qualified to deal with me.

(Male, 28 years)

8.2.4 Improvements to Homeless Services – Service User Perspective

All participants were asked how homeless services could be improved. In terms of general comments regarding improvements, increased quantity of services was recommended. In particular, respondents stressed the need for specialised accommodation for different homeless groups such as; couples, families, young people, drinkers, drug users and individuals with mental health issues. More resources were also thought to be important to target the issue of homelessness in order to encourage pathways out of homelessness. Less restriction in opening hours and appointment-based systems were also stated as well as a more comprehensive delivery of homeless services.

Improvements regarding policy on the use of drugs and/or alcohol were also stated by both users and non users alike. Figure 8.2 illustrates references made to the issue of drugs and/or alcohol use which, according to respondents would seek to improve homeless services.

Figure 8.2 Improvements to Homeless Services (Drugs/Alcohol)

I think drug users, alcohol users, non-alcohol users and non-drug users should be in separate accommodation.

(Female, 26 years)

People on methadone should not be mixed with people on drugs. It is very hard when you start on methadone and someone is offering you drugs and they're everywhere. If you're in a place with other people just on methadone it makes it easier.

(Female, 30 years)

You could cater for homeless drug addicts a lot better by having a building we could use, which is supervised and you would not be arrested for using.

(Male, 55 years)

Drug users should not be allowed to bring drugs into hostels. They should be searched for drugs. They know they have drugs and turn a blind eye to it.

(Male, 55 years)

They could start helping people who are coming off the gear. They still push us away.

(Male, 23 years)

You need separate hostels. Drug users and alcoholics don't get on, they are old men and mixing with younger men, thinking they are supermen and hitting them.

(Male, 28 years)

You need to separate the genuine homeless from the scumbags who only want to drink and get smack.

(Male, 52 years)

8.3 Homeless Services Provision: the Provider Perspective

Policies

Few of the representatives from homeless agencies interviewed had official policies on illicit drug use, possession and dealing. However, all agencies stated that they did not allow drug use or drug dealing on their premises, and clients who did not comply were sanctioned.

In the service we would bar for suspicion of use or dealing and that is because it is illegal. It's not being overreactive [...] we've had lots of incidents of people trading in some kind of heavy stuff. We just bar them then. If somebody wants to go out and use we say okay. We don't condone it – we say okay, not on the premises.

(Homeless service provider – Cork)

Even though our policy is very flexible on drug use you get the young people who come in and use in the shower or in the toilet and they get a week probably or two weeks.

(Homeless service provider – Dublin)

Policies around other drug-related incidents (e.g. behavioural problems) were more flexible and implemented at the discretion of staff.

Our policies are documented for staff and we would spend a lot of time reviewing policies, what is practical and what can work.

(Day service provider – Dublin)

I was just having this conversation the other day with a staff member about what is acceptable within the confines of our accommodation.

(Homeless service provider – Limerick)

Service providers also encouraged clients not to use outside their premises in order to limit community complaints about anti-social behaviour.

We have a policy outside, if they are seen using or drinking or selling or fighting whatever they wouldn't be allowed in [...] If they are seen using they can be barred for a day or a week. It depends, if they are caught once it could be a day, if they are caught twice it could be a week, if they are caught three times it could be a month. It just depends – we try and get the message across that way. We would be quite flexible in that area – we would have a bit of room to manoeuvre.

(Day centre provider – Dublin)

Unlike some accommodation providers, no day services who participated in the focus groups stated that they would refuse homeless drug users. This respondent's comments are typical of many homeless service providers.

At the other end of the day we work with everyone no matter what they are on and we have only one policy which mainly helps, you can come in as off your head as you want to be as long as you can stay awake and keep it together and don't use on the premises.

(Day service provider – Dublin)

Due to the nature of their work, settlement services were the only homeless services who did not find it suitable to work with current drug users, and they stated that they were only willing to work with stabilised drug users.

Chaotic drug users – I hate to use the word excluded because there is not anybody excluded from our policy but because we are settlement workers you cannot work towards settlement if they are chaotically using drugs. There is a different priority.

(Settlement worker – Dublin)

Chaotic drug users, in terms of settlement, it doesn't really work because they miss appointments. Obviously their priorities are different and we feel they need a different support than we can offer because we are not drug counsellors.

(Settlement worker – Dublin).

Challenges to Service Provision

As already stated, homeless service providers in the four cities felt that the number of homeless people engaging in drug use was increasing, in particular the proportion of polydrug users. This perception is reflected in the results of the survey which found that 45% of homeless people interviewed were polydrug users. As a result, service providers found it particularly challenging to firstly detect drug use and secondly recognise the signs and symptoms of different drugs.

Some people will tell you that they use drugs but it is all kinds and sometimes if you work with somebody it is very difficult to know what they are or are not using as they are not very forthcoming.

(Homeless service provider – Cork)

You wouldn't really know whether it was methamphetamines or speed or coke and again it is about the behaviour that is going with it and paranoia.

(Accommodation service provider – Dublin)

But often there are clients coming and telling us that they had cocaine and a lot more of the drinkers lately are coming and saying they've been taking coke as well. But it is really hard to know what kind of substances they are using, unless you know the person really well or is it mental health?

(Shelter worker – Dublin)

Furthermore, homeless service providers stressed that they needed to be more adaptable and able to deal with a wide range of issues simultaneously when working with homeless drug users.

Their lifestyle is a more chaotic lifestyle. It's not black and white. That's the difference. Their needs are greater. You need to be more flexible – offer more support – to try and link in with the other services as much as you can – to make the next appointments.

(Primary health care provider – Dublin)

It's the whole big melting pot of everything. You cannot deal with one issue and come back to the other one later on. It's very difficult to deal with all the issues at once.

(Homeless service provider – Cork)

Staff working successfully with homeless drug users in a shelter in Dublin stated that a significant challenge was addressing their own preconceptions of homeless drug users.

The staff themselves had to do a lot of work. The hostel was traditionally accommodation for drinkers. The staff that had been there for quite a while were in that mode of "we couldn't possibly work with drug users because a lot of the stuff they're using today is because of this, that and the other." Some of them were pure myths so the staff had to do a lot of work around that.

(Accommodation service provider – Dublin)

Another specific challenge related to homeless drug users was the fear around death by overdose.

If someone ODs [overdoses] during the night you are not going to find that person until the next morning. You don't want to be the person who finds that person. That would be the genuine concern why so many of them are actually being refused services from the residential units – it's not because we are drug free as such it's because of the consequences if they OD during the night.

(Homeless service provider – Dublin)

Homeless service providers were also concerned about staff and client safety, although there were no specific drug-related incidents reported during the focus groups.

Interviewer: What are the reasons for the residential programmes not accepting active drug users?

I suppose safety is the biggest one especially in relation to the other clients.

(Homeless service provider – Dublin)

Finally service providers found it particularly difficult to motivate some homeless drug users, in particular younger clients, away from drugs or to offer alternatives.

Interviewer: What are the main challenges in working with young homeless drug users?

Most cases it is hard to motivate them to actually even look at their drug use.

(Service provider – under 18s – Dublin)

The whole culture is if you take the drugs out of it the kids, they loose an awful lot, their friends, and their social life.

(Service provider – under 18s – Dublin)

Barriers to Service Provision

While many homeless service providers felt services had improved for homeless alcohol users overall, they believed that homeless services do not adequately meet the needs of homeless drug users.

The main thing is the Homeless Agency has not properly dealt with the drug issue and homelessness. That is possibly something that should be passed back to the Homeless Agency. Why are they not providing the proper facilities for people addicted to drugs? There are loads of

facilities for people who are addicted to alcohol but not so many proper facilities for people who are addicted to drugs. So that is possibly something that should be passed back to Parkgate Hall – why are they not doing it?

(Day service provider – Dublin)

A minority of agencies, mainly in Dublin, felt that their staff were competent in dealing with homeless drug users. Conversely, most agencies stated that a lot of their generic workers had little or no drugs training and very few had a dedicated drugs worker.

I realised very quickly when I started working with homeless people that I did not know anything about alcohol or drugs and all the clients were either serious drinkers or drug users. But most people that I have worked with didn't and they would carry prejudices with them.

(Homeless service providers – Galway)

Some of the staff might have a limited knowledge of drugs. Most would have a good knowledge of alcohol. Again, we were originally set up to deal with alcohol. Some of the staff would have a better knowledge of drug addiction than I would have. Again, most of the people that I work with would have more knowledge of alcohol addiction. If we do come across someone who is addicted to other drugs we tend to refer them on.

(Accommodation provider – Dublin)

Lack of training can result in many staff being unwilling to work with homeless drug users. Even staff members who have received training in drugs issues may still not feel competent in working with this client group.

We did form a policy which identified that we would work with drug users but it never worked out. Primarily because the staff didn't feel comfortable with them. The majority of the staff did not have training, experience or education in that area, and felt very unfit.

(Service provider – under 18s – Dublin)

And experience as well, every staff member in our place would have varying levels of drug training, I think the majority of them did a drugs awareness course but in terms of actually feeling comfortable to go on a shift especially because our place has independent units which are self-contained, the training does not give them the reality of experience.

(Service provider – under 18s – Dublin)

Therefore, lack of experience and the negative attitude of some staff members towards drug users also acted as barriers to service provision.

That is exactly where experience comes in where you would know instinctively, people who are experienced would feel comfortable but the simple reason that someone is a heroin user is not the problem, in my case I did not really like it initially but I did have to accept that.

(Service provider – under 18s)

Lack of resources and funding restrictions were given as the two main reasons for lack of adequate training.

Our funds are a third of what [another homeless hostel] is getting so we cannot afford to train our staff in the proper way because the funds are not there.

(Accommodation service provider – Dublin)

Because we're not paid the same type of money as [another homeless service] we're on a much lower bracket – they have a lot more experience – we can't afford it – this is where the problem is.

(Accommodation service provider – Dublin).

Furthermore, homeless services that adopt an abstinence-oriented approach, as opposed to harm reduction, are more likely to alienate certain groups of homeless drug users.

Some people signed on to work with homeless people because they wanted to stop people from drinking or using drugs and to stop people from doing this and that and they did not sign on for the harm reduction and I think that can be quite hard for some people.

(Homeless service provider – Galway)

I suppose it depends on what your goal is, what your aim is. Sometimes we get caught up in trying to get them clean and trying to get them drug free when they are not ready for that. We should facilitate them at where they are right now and that might be as a drug user so what can we do – get them a bit of help from the health promotion unit to make sure they are injecting okay, lets try and encourage them to eat so as their physical health can improve.

(Accommodation service provider – Dublin)

Service providers in Galway complained that they had no outreach service targeting homeless drug users which could result in some of them not being linked into any services.

You have got the group that we just talked about that are excluded that are out there that nobody is making any contact with and it is about trying to access them.

(Homeless service provider – Galway)

Another barrier cited was that there are no day services specifically targeted at the needs of homeless drug users.

Our clients would, I think, argue that there is nothing for them in terms of what they do during the day, specifically for homeless drug users. You could question the availability of different kinds of services that could be on offer to them [...] I think there is a gap there in terms of the people I work with who are chaotic during the day.

(Accommodation service provider – Dublin)

I suppose maybe they are doing the same thing all day every day and I'm not sure what the answer is but there is a gap there for people who are in a night shelter.

(Accommodation service provider – Dublin)

Accommodation

Although the increase in the number of accommodation services willing to accept homeless drug users is positive, some service providers pointed out that the quality of these services was often poor.

You talk to the clients themselves about hostels; the majority of them will tell you that you need to be stoned to sleep in the place. Even when you are stoned you have to lie there with one eye open because as soon as both eyes shut somebody is robbing your boots or they're doing something. You cannot relax in those places.

(Outreach worker – Dublin)

Furthermore, many felt that there is no continuum of care for homeless drug users and that there are no move-on options from emergency accommodation in any of the four cities.

One of the problems there is that people are there on a long-term basis which was not the original idea behind it – it was supposed to be a short, one night or two night respite [...] I'm meant to be offering emergency accommodation – I'm not meant to see people three nights in a row but I'm dealing with the same people for the last two years, the same people [...] Move on could be to another emergency accommodation which is technically meant to be another emergency service.

(Night shelter provider – Dublin)

If, at this level, you see a window of opportunity to intervene in someone's drinking and drug patterns – and someone wants to stop – there is no way of saying – okay, here are the four or five steps that can help you [...] There is no service beyond emergency crisis provision.

(Homeless service provider – Galway)

Although no individuals under eighteen years were recruited for administration of the survey, there was much debate among service providers in relation to providing accommodation for homeless drug users of this age group. While one respondent pointed out there was no accommodation specifically targeting young homeless drug users, the majority of service providers felt that such a specialised service would stigmatise this group.

Respondent 1: If a residential accepted drug users, it would be very effective. From assessment you have a very good idea of who is going to succeed on a residential programme, because you are thinking, here is a kid with a chance and here is a kid who is a drug user – you would like to give both of them a chance but they have got only one place and the place costs so much per year and that is the way it is, so on that basis you give it to the non-drug users. I think as a stepping stone, that a residential unit would be good.

Respondent 2: As well we would have reservations about even 18/19 year-olds but certainly under 18 year-olds in being able to identify themselves by putting them in a hostel for drug users and putting a name on them, it is setting them up on the track. Personally I think they should be dealt with individually, I think the idea of a hostel for drug users is horrific.

Respondent 3: [...] it is that they would be identified as active drug users, kind of setting them up for a fall [...]

Respondent 4: *If you are talking about a residential drug unit you need to identify what is the main purpose for it (a) is it because they are homeless (b) is to address the drugs issue. To address the drugs issue I disagree, I think a residential unit for under 18s is not the way to go. I think if it's to address their immediate housing need probably, yes.*

Several other gaps in service provision were mentioned that affect all homeless people. In Dublin it was pointed out that homeless clients are drawn into the city centre because of lack of good local services and there is a lack of support for homeless women. Furthermore, there was no accommodation for couples and service providers felt that the long-term use of B&B was unacceptable. Homeless service providers in Limerick highlighted that there was no evening outreach service for rough sleepers and expressed a need to extend the opening of day centres to the weekends. In Galway, homeless service providers were concerned about the lack of aftercare workers.

Successes

Service providers were asked to describe their successes in working with homeless drug users. Focusing on an individual's behaviour, rather than drug use, was frequently noted by respondents in Dublin as a positive approach to crisis interventions:

One of our main successes in dealing with homeless drug users was focusing on behaviour and not the drug use.

(Accommodation service provider – Dublin)

The group work is based around behaviour and it is not about discussing drink and drugs. So it is kind of moving away from what they are dependent on and looking more at the client and what they need. Looking at their behaviour and any way of changing it. So there is no stereotyping people and I think that is good [...] It is creating a more open-minded attitude among service users and possibly among people who are working with them – a more open mind about drug use and I would say some of them are quite wary of people that are coming in who would be active drug users so it helps to dispel myths about it and fears that they might have.

(Accommodation service provider – Dublin)

According to several homeless service providers, a key feature of successful service provision to homeless drug users is flexibility.

I think one of the strengths in all of the services is the flexibility.

(Homeless service provider – Cork)

I think flexibility is the key and then you manage to get someone on.

(Homeless service provider – Galway)

Given the multitude of issues homeless drug users present with, homeless service providers in Dublin and Cork felt that their multi-disciplinary teams had vastly improved social care for this target group.

The biggest thing now is the multi-disciplinary team which is very successful. It is only for over eightheens. It is allegedly the first one in the country – there are two in Dublin. [...] We are very lucky in that there is a GP, an addiction counsellor, mental health nurses, psychiatrists, a public health nurse and health promotion officers. As well as that we have the community welfare

officers. So, if I see somebody and they have a skin problem and they need new clothes because of their skin condition or they need a shower every day or whatever – I can get on to the homeless unit, the community welfare officer and write a letter and say this person is coming down and he needs this specifically for this treatment. Then we can sort that out.

(Primary health care provider – Cork)

Separate or generic?

There was much debate during the focus groups in relation to whether service provision should be specialist or generalist. In relation to accommodation services, the prevalent feeling was that chaotic drug users should be accommodated separately, but more stable drug users should be able to share accommodation with non drug users. However, it was pointed out that any accommodation provided to active drug users needed to meet their needs by providing needle exchanges and sharps boxes in rooms.

If you are just homeless you don't want to be sharing with a load of drug users. You've your own issues and they have their own issues. I think at first they should be separate but once the drug users start showing that they are willing and stabilising or things are happening for them – I don't think they should be kept separate after that.

(Outreach worker – Dublin)

They need specific shelters where everything is geared for their needs. You do need to have sharps boxes, you do need to have a needle exchange and you do need to have sterile water. Everything should be specifically designed for that person's needs.

(Night shelter worker – Dublin)

Many service providers felt that separate services were important as younger homeless people could be easily influenced by older drug users. Furthermore, service providers often pointed out that a drug-using environment is also not conducive to an ex-user sustaining a drug-free lifestyle. Several respondents also felt that drug users and drinkers should also be accommodated separately as the general feeling was that these two groups often antagonised each other.

I have worked with drinkers [...] who consider themselves morally superior to a recreational cannabis user, that's how serious it is, and also IV drug users just don't like any drinkers, even though they might drink themselves.

(Drug service provider – Galway)

We would also have the problem if more and more drug addicts come into the building then our street drinkers will not stay. At one stage our service had to be closed down because more drug users were coming in so the street drinkers decided not to come in.

(Emergency hostel worker – Dublin)

This view was reiterated by another respondent who explained that if a service is dominated by homeless drug users it can deter other homeless people from accessing services.

I have talked to different homeless people and services providers in hostels and lots of them said "we won't go near [that service] – there's drugs in that [service]".

(Primary health care provider – Dublin)

Conversely, a minority of service providers did not agree with specialist services as they felt they “ghettoised” and “stigmatised” homeless drug users. As one respondent explained:

I think the idea of a hostel for drug users is horrific. It is horrific being identified as active drug users and it is kind of setting them up for a fall [...] drug use is a behaviour, it is not what somebody is.

(Under 18 service provider – Dublin)

Service Development

Service providers emphasised that it was difficult to improve existing services and develop new programmes due to lack of necessary resources and funding. Therefore, they stressed the need for the support and commitment of the appropriate funding bodies.

An awful lot of that stuff is actually there in the homeless action plan – they have identified it – it is actually about having legislative teeth attached to that plan so that we can say – “right, we’re going to have that day centre that we said, we’ll have it where there will be supports for people, where they know there will be maybe a GP”.

(Homeless service provider – Cork)

As already mentioned, service providers thought that the most appropriate way of providing services to homeless people was using multi-disciplinary teams, preferably all working in the same location.

If we have them all under one roof, so if somebody walks into the centre they could be going to use any service. We could maybe pull in the addiction services to be based here as well. People would feel more at home or less intimidated to see somebody. It just seems to be the best direction to take in terms of providing a one-stop shop.

(Homeless service provider – Limerick)

It was felt that a multi-disciplinary teams could also assist service providers in offering a continuum of care and setting out clear settlement plans for homeless drug users.

If you can have something that is provided where the staff are involved from the very start of the process up to transitional and beyond that again into community support. I think we fall down a lot in just dealing with the immediate problem – you need to have a clear plan in your head when you are working with people. I think that is where we need to be going.

(Worker in drop-in centre – Dublin)

It was also advised that multi-disciplinary teams should also include designated psychiatric workers to address the issue of dual diagnosis amongst this group. Service providers also pointed out a need to increase the number of acute beds in psychiatric hospitals in order to deal with this issue.

As far as I am aware there are no dual diagnosis workers in the Western Health Board although maybe possibly the existing alcohol addiction counsellors consider themselves to be dual diagnosis experts but there are no designated workers.

(Homeless service provider – Galway)

You have to gather all the collateral information, the hostel are ready to kill you because you have done nothing for three weeks or longer. Then you have the information which allows you make a decision – you ring up the hospital to try to admit them and there are no beds. Again, they are only working with the resources that they have. That is such a major, major, ethical, moral, unfair problem.

(Primary health care provider – Cork)

Accommodation

Service providers in Galway expressed a need for a low threshold hostel in the city that would accommodate homeless people who used alcohol and drugs.

It will have to be a place where people will be allowed to drink, because there is a homeless street drinker population in Galway but it would have to also bring in chaotic drug users.

(Homeless service provider – Galway)

Several respondents stressed a need for individual rooms in hostels for homeless drug users, providing locker facilities and harm reduction measures (such as sharps bins).

A client needs an individual room with a locker where he can put his stuff for the day. It's soul destroying having to try to walk around with a big rucksack on you, with a sleeping bag tucked under your arm and everything and try and get things done around town. If you had somewhere you could leave your stuff, where you knew when you came back that night your stuff was still going to be there. It would be as clean as you wanted it to be, at least it would give them a bit of dignity. At the moment there is no dignity.

(Outreach worker – Dublin)

The locker system down there – it is very practical – it makes a big difference but unfortunately people are not able to access that during the day [...] That would make a big difference to people in their day-to-day experience of being a homeless drug user.

(Worker in drop-in centre – Dublin)

In fact, service providers in Dublin and Galway felt harm reduction measures should be located in all homeless services.

There is a need for all services to have a sharps box and they can – it costs a lot of money and no one is prepared to take boxes off us.

(Homeless service provider – Galway)

Although they acknowledged there were legal complications, service providers in Dublin recommended setting up an emergency hostel for homeless drug users where they can use drugs on the premises.

We also need low-threshold night shelters specifically for the drug addicted person. Not a shelter where they are going to mix with street drinkers or whatever but they need specific shelters where everything is geared for their needs. You do need to have sharps bins, needle exchange and sterile water. Everything should be specifically designed for that person's needs.

(Night shelter worker – Dublin)

Going back to the emergency accommodation, I think it would be fantastic if we had somewhere where active drug users could go and they had ongoing support and they could use in there.

(Outreach worker – Dublin)

To ensure that homeless drug users receive a continuum of care, homeless service providers emphasised the necessity of move-on accommodation from emergency hostels, offering different degrees of support.

It does work for a lot of clients. We have moved a lot of clients into transitional accommodation in the last year. It has been really encouraging to see them come from rough sleeper right the way through into transition and see them doing well. You are always going to get people who don't do well but it is really encouraging. I think there needs to be more of that system. Obviously not every shelter has the ability to cope with that. They don't have the space that we have or the number of beds. But there needs to be that step-by-step process.

(Night shelter worker – Dublin)

Some clients need to be somewhere in between – high support, smaller, about ten beds, single rooms. Maybe not having to get out at 9.30 a.m. in the morning maybe out at 12.00 in the day – if they go out at 9.00 a.m. they can come back in the afternoon and you can do that kind of key working with them. It's difficult for ourselves – we provide key working but the level we provide is questionable.

(Hostel worker – Dublin)

Service providers in all four cities also expressed the need for half-way houses, targeted at homeless drug users who may have relapsed after a treatment programme.

What I would like to see here is – they have it in the UK and definitely in America – I have been over to the States and have seen it operating. They have a half-way house. The only facilities we have here in the Munster region is that you have to complete a treatment programme. Complete primary treatment and then you are considered for a half-way house. In the Homeless Unit the majority of people I have met, they have failed – they see themselves as failing four or five or seven different treatments. They don't come into that region at all. I would like to see a half-way house facilitated by staff and a sober house following on to support that. It works in other countries.

(Homeless service provider – Cork)

There was also a broad consensus among service providers that the availability of transitional housing for homeless clients on methadone maintenance, or for those who have become drug free, needed to be increased.

A lot of people come through our doors that would be on methadone. To get accommodation is very hard because Dublin Corporation won't house people on methadone. There are lots of people on methadone that you would not even know are on methadone. People on methadone need to be sustained, so there should be a lot more transition for people on methadone.

(Settlement worker – Dublin)

What I would like to see is – if somebody was on a methadone maintenance programme and it was working for them, they weren't continuing to dabble, they were doing okay and they wanted to get accommodation specifically for people on methadone maintenance programmes, that that would be available for them.

(Hostel provider – Dublin)

If somebody is trying to stay off drugs or drink there is nowhere they can go that they know [drugs or drink] are not going to be in their face or [are] not going to be pushed on them.

(Outreach worker – Dublin)

For those homeless drug users who become drug free and obtain stable accommodation, it is still essential that they receive adequate settlement support. As one provider explained:

What we found as well is that eventually when they do get houses and it is so long since they were in a house that they seem to have no concept of how to look after the house – they are allowing people to come in and cut up heroin in the house and all sort of things going on that result in having them evicted again. Whereas if there was a worker there working with them to resettle them into the house and support them – there would be a better chance of them keeping the house, looking after it and getting back into some sort of normal family life.

(Homeless service provider – Dublin)

According to some homeless service providers, resettlement for homeless drug users could also be facilitated by gaining the support of local authorities and private landlords.

If some local authority tenancies [...] would take responsibility for supporting the person in that accommodation and helping them to maintain the property properly, helping them to pay their rent, etc. but also helping them to try and maintain their lifestyle free of the issues that they want to get away from – their drug or alcohol use or whatever.

(Homeless service provider – Galway)

I think to have more programmes which would link in with private landlords [...] that they have some agreement as such to back this up if someone falls short, that would be a brilliant idea, because it would be an indication also that somebody is maybe slipping and that you could catch it before it actually snowballs so you have the landlord in on the deal as well that would be a really good idea.

(Drug service provider – Dublin)

8.4 Drug Services

8.4.1 Contact with Drug Services

Only individuals who reported a score of 3 or more on the DAST screening instrument were asked questions regarding contact with drug services over the last three months (n=162; 86%). This was to ensure that questions regarding contact with drug services were not inappropriately asked to those who would define themselves as recreational users. Under this condition, 80% (n=129) reported contact with a drug service within the last three months, representing 36% of the total population. The majority of respondents reported contact with drop-in centres (n=80; 52%), while contact with methadone maintenance services was reported by 50% (n=77). This represents 23% and 22% of the total study population respectively. Although not significant, a higher proportion of male respondents 55% (n=42), than female respondents 45% (n=35) reported contact with methadone treatment services within the last month.

Among those who scored 3 or more on the DAST screening instrument 39% (n = 61) reported contact with a syringe exchange within the 4 weeks prior to interview, which represented 17% of the overall study sample and 86% of current injectors. The mean age of those in contact with syringe exchanges was 28 years (median=27; range 18-51 years) in comparison to a mean age of 29 years for those in contact with methadone treatment (median=28; range 18-51 years). In terms of syringe exchange contact by accommodation type, this represents 11% of the total hostel dwellers, 28% of those staying in B&B accommodation and 29% of those sleeping rough respectively. Thirty percent (n=46) reported having had contact with counselling services within the last month, which represents 4% of the total study population. One-in-four of the respondents reported contact with drug outreach services (n=40; 26%), representing 11% of the study population. A considerable number also reported having attended Narcotic Anonymous over the past month (n=29; 19%), 8% of the total study population. Less than 10% of applicable respondents reported contact with either outpatient (n=14; 9%) detox facilities, inpatient detox facilities (n=12; 8%), community addiction teams (n=11; 7%) or residential drug-free programmes (n=11; 7%).

8.4.2 Difficulties Accessing Drug Services

As already stated, only individuals who reported a score of 3 or more on the DAST screening instrument were eligible to answer questions regarding difficulties accessing drug services (n=162; 86%). The majority of respondents (n=114; 75%) reported that they had never experienced any difficulties in relation to accessing drug services. Of those who did report difficulties, many of the issues raised were reflective of areas which are constantly debated in terms of accessing drug service provision including difficulties accessing detox and methadone maintenance programmes.

Figure 8.3 Difficulties Accessing Drug Services

I need a benzo detox, it's a big problem in Dublin and no one can do me a benzo detox.
(Male, 23 years)

The waiting list for methadone was nearly 18 months and it took nine months to get an assessment for methadone.
(Male, 23 years)

When I was 16, an outreach worker got me onto [a treatment programme]. They wouldn't take me on anywhere else. I would have preferred somewhere locally to stop meeting people using. I ended up using more.
(Female, 30 years)

However, when respondents were specifically asked if they had ever experienced any difficulties accessing methadone treatment, almost half reported having experienced difficulties (n=69; 46%). Figure 8.4 highlights the main difficulties cited by respondents including the length of waiting lists and the inability of individuals to access treatment services when they were motivated and were required.

Figure 8.4 Difficulties Accessing Methadone Treatment Services

The waiting lists are very long. When I was on a programme I came off it and then wanted to go back on maintenance but could not because I had no address and got refused.
(Male, 22 years)

It was too long of a waiting list. It was only when I went into hospital with an infection I was put straight onto a programme after waiting a year.
(Female, 23 years)

I wanted detox – just two weeks of it. I didn't want a maintenance for the rest of me life.
(Male, 25 years)

8.4.3 Improvements to Drug Services – Service User Perspective

Respondents were also asked to state the manner in which drug services could be improved upon to cater for the homeless population. The most commonly cited recommendations included reduction in length of waiting lists, increase in day services and drop-in centres as well as increased availability and access to needle exchanges. Reducing the need for people to travel to drug services was also stated. Figure 8.5 conveys some common responses which would specifically target the needs of homeless drug users.

Figure 8.5 Improvements to Drug Services (Service User Perspective)

They should legalise heroin in clinics to stop dirty heroin on the streets. We need injecting facilities to stop needles on the street.

(Male, 28 years)

We should have easier access to programmes and a short wait between first visit and being taken onto the programme.

(Male, 52 years)

They give you syringes but you still have to go out into the streets and use. There should be a building where you can use to minimise the risk of overdosing.

(Male, 23 years)

Clinics should work out how they work with the alcoholics and the junkies.

(Male, 23 years)

There are places out there that won't take people that don't have an address and a doctor. But I think everyone should be taken on even without an address – I know people who would love to get on it [methadone programme] but don't have an address.

(Male, 34 years)

They need to end catchment areas as persons from Kildare must go to Trinity Court.

(Female, 23 years)

Drug services could contact the Corporation and get places. We could sign an agreement to be clean.

(Male, 27 years)

The homeless should be given priority for methadone. Those that aren't homeless have family support. If you are homeless you should also be given priority for residential.

(Male, 39 years)

8.5 Drug Service Provision: the Provider Perspective

Policies

Despite increasing numbers of homeless drug users, no drug agency interviewed reported that they had a policy on how to deal with homeless clients. As one GP remarked:

Of course every person dealing with substitute prescribing is likely to encounter the problem of homelessness at some stage and there are certainly in my ward no specific policies around homelessness. That is to say there is no specific approach to the treatment of homeless persons which varies from the treatment of any other person. There is a homeless unit which is dedicated to seeking, if you like, to assisting persons who require treatment and/or accommodation, but that unit does not have any dedicated substitute prescribing facilities for the homeless, so it is really only in the position of any other advocate requesting a service.

(Prescribing GP – Dublin)

Challenges

According to drug service providers, the main challenge in working with homeless drug users was trying to meet their multiple needs:

Well, I am not sure that their needs are different but how we meet those needs may have to be modified. They have greater needs because they also have the accommodation issue. They have the issues of not being safe and of being more vulnerable to everything from being picked up to having to become involved in crime or being physically assaulted. Their needs are more than the needs of those that may have some accommodation.

(Drug service provider – Limerick)

Another challenge reported was engaging with homeless individuals who did not want to give up drugs.

Some people will not go on methadone for love nor money. They don't want it. They are taking drugs. They're using the gear. They're not using the gear. It's very, very difficult to try and work with somebody like that.

(Drug service provider – Dublin)

Service providers in Cork and Galway found it frustrating to work within the confines of an abstinence-oriented model:

If you are looking for maintenance there is an attitude in the Health Board that if you introduce it or make it available you will increase the problem. Okay that is true, but then there are a lot of people I think within the area who go to Dublin to fulfil whatever need they have around heroin or methadone.

(Drug service provider – Cork)

Respondent 1: There is no Harm Reduction model.

Respondent 2: And there is no understanding around the Harm Reduction Model.

(Drug service providers – Galway)

Barriers to Service Provision

In discussing one drug service in Dublin that specifically caters for the needs of homeless drug users, some service providers complained about the quality of the service provided there. One GP described it as 'the service of last resort'. There is no other service in Ireland specifically targeted at the needs of homeless drug users.

I think one of the difficulties I find in Cork as opposed to anywhere else I have been is that there is no specific response to drugs as such. We have emergency hostels for homeless people, we have certain housing options. There is a little bit around alcohol but specific drug projects are not here. I think this is a big gap.

(Drug service provider – Cork)

Many service providers felt that the drug services homeless people accessed were often under-resourced, short-staffed and sometimes of poor quality.

Interviewer: *How would you rate drug services in the way they cater for homeless people?*

Respondent 1: *Out of hundred – I would lay it about five.*

Interviewer: *Would the rest of you agree?*

Respondents: *Yes.*

(Drug service providers – Dublin).

It would be an issue for me because in reality any organisation here – our resources are being cut. There is no point in providing a service if you don't have quality. It is pointless.

(Residential worker – Dublin)

They come and we try to access accommodation and appropriate resources but the support they require to be able to manage is not being put into the system.

(Drug service provider – Limerick)

This point is further illustrated by the following nurse who described how she was trying to run a detox unit, under-resourced and under-staffed:

It's crazy. The service, I have to say, is absolutely laughable. The only people who are in there are us, the nurses. I'm a general nurse. I have no training in addiction. We have no counsellor. We lost our counsellor in November.

(Drug service provider – Dublin)

Other problems with service provision, such as bad management and lack of training were summed up by the following respondent:

Interviewer: *What do you think the weaknesses are [in drug service provision]?*

Respondent: *The weaknesses are bad management, bad consultation, and lack of training. You could go on for ever – but they're the major ones.*

(Outreach worker – Dublin)

Waiting lists and appointments in drug services were reported to deter homeless drug users from accessing drug treatment.

Because of the nature of the business, if you are homeless, or you are dealing with people in addiction, they need a very instant response and not to be waiting a month or six weeks down the line.

(Drug service provider – Cork)

They could have access to our service, but that could be by appointment. People who are homeless and on the street and are chaotic are not going to keep appointments.

(Drug service provider – Cork)

Low Threshold Services

There are no needle exchanges in Cork, Galway and Limerick, although service providers in Galway and Limerick expressed a need for such a service. If such a system was set up, however, the confidentiality and anonymity of clients would have to be respected:

Interviewer: Would people be concerned about any stigma associated with going to their local pharmacy to get needles?

I'm sure they would. Hurdle number one is attitude. They might have to travel fifteen miles from another village to get their medication. Yes, there would be huge stigma – you are talking about from a client perspective.

(Drug service provider – Limerick)

Two serious gaps highlighted in low-threshold services in Dublin were the absence of any needle exchanges in the evening and at weekends, and the lack of facilities to dispose of needles safely, especially given the difficulty homeless drug users face in accessing clean injecting equipment.

I cannot see the point in having every needle exchange open from 2.00 – 5.00 or from 9.00 to 5.00. There should be at least one somewhere in the city that is doing night-time work [...] I think there needs to be something set up at night-time and weekends. There has to be recognition that drug users need needles at the weekend and the night-time as well. It's all very well saying that they can go into the exchanges during the day but knowing drug users all they can see is the next turn on. Weekends and night-times around here the price of a barrel and spike would be about €15.00.

(Outreach worker – Dublin)

We decided that we would leave a bucket out there because there were an awful lot of clients using there. So we left a bucket there all week and it was filled up [with needles]. We put another one in on Friday and that was full up.

(Outreach worker – Dublin)

Methadone Maintenance

One service provider, with years of experience prescribing methadone to homeless drug users, described the 1998 Methadone Protocol as a 'red herring'⁶⁶. In his view, it discriminates against homeless clients as it allows level 2 GPs to choose their clients (usually the more stable and reliable), and those that are unwilling to deal with homeless clients can avoid them.

There are few solutions to the problem of the homeless with the Protocol. I suspect that probably what you will be looking at in the future is an increasing detachment of general practice for this group, it will be harder not only to get methadone for them under the protocol but to get any kind of medical care services at all and this is the experience internationally and general doctors do not want to deal with this group, they have to be looked after by paramedics. That is the way it is worldwide to my knowledge.

(Drug service provider – Dublin)

In several focus groups, the participants cited a number of anomalies with the prescribing of methadone maintenance to homeless people in Ireland. Difficulties homeless drug users had in accessing methadone maintenance treatment included lack of permanent address, waiting lists, keeping appointments and harsh sanctioning for failing urinalysis.

I find it is hard to get somebody up and running if they don't have a steady address. There are more obstacles put in their way. Then as it goes on through the whole thing with the pharmacy, they are reluctant as well to work with people who are homeless because of the hostel situation.

(Drug service provider – Dublin)

One thing that he [homeless client] is finding is that it is virtually impossible to stick to any time constraints and invariably will sort of push the boat out in terms of being a little bit late. I don't enforce any time constraints but the boss does and we have already had one or two battles of words about it.

(Prescribing GP – Dublin)

Some of the doctors are grand – they let you do this and do that – a lot of the doctors are so terrified of being sued that as soon as a client comes in and starts showing dirty urines they will put them on harm reduction straight away. They go from the level of say 100 mls. to 20 mls. They're setting someone up all the time. Some of the clients that you talk to – they've got used to 100 mls. – they're probably dabbling and messing around on top of that and all of a sudden they're knocked down to 20 – that's a terrible regime.

(Outreach worker – Dublin)

66 The Department of Health and Children introduced a new protocol for the prescribing of methadone maintenance in October 1998. This resulted in strict regulations to reduce the problems of double prescribing and the availability of methadone on the black market. For more information refer to Butler, S. 2002 'The Making of the Methadone Protocol: the Irish System?' *Drugs: Education, Prevention and Policy*: 9: 4: 311-324.

Furthermore, several service providers pointed out during the focus groups that expecting homeless drug users to attend methadone clinics on a daily basis may prevent them from accessing stable accommodation or employment.

But it also comes back to the other thing that while there are obvious advantages to a very high level of supervision it is very destructive in your life, it can prevent them getting a job and prevent them taking up a residence outside what is very local, if they are going to have to attend every day, it can actually hold them back in other ways.

(Pharmacist – Dublin)

Now many of those are required daily attendants and of course the logistics of coming from Swords, from Inchicore, especially at weekends to clinics for an hour in the mornings clearly is a problem. This is how you acquire the homeless problem.

(Drug service provider – Dublin)

Other problems mentioned with methadone prescribing were not specific to homeless drug users. These included that some service providers were concerned about the length of time clients were on methadone, others felt it was a way of controlling heroin users rather than stabilising them, and several service providers complained about the over-prescription of methadone and other prescription drugs.

Treatment

Overall service providers did not feel that there were enough detox beds and residential units in Dublin and Cork to meet the demand among the drug-using homeless population.

The first point is that it is very, very difficult to get somebody a detox bed and that is what is needed for the homeless in Cork and it is also needed for the whole population in the Southern Health Board.

(Homeless service provider – Cork)

We do see and find a means to spur them on to projects, and other programmes and it is very hard to move them on in the sense of getting residential beds and on to courses [...] There is also a big gap there with different residential units, a lot of the residential units would not be able to take chaotic drug users.

(Homeless service provider – under 18s – Dublin)

Furthermore, service providers in Galway and Limerick stressed that there were no accessible detox places for homeless drug users in their areas.

Respondent 1: One of the greatest needs I would say, for our homeless clientele and any of our clientele really, would be an easily accessible detox. People may not necessarily want to try to come off, but they know that their health is at such risk that they definitely need a break and they need to detox.

Respondent 2: It is like, if you have someone come to you and say that they want to detox, realistically there is not much they can do, they are miles away, there is nothing locally and if somebody is homeless you get into this whole rigmarole of how long have you been in the area.

(Drug service providers – Galway)

The problem is that they have to go into residential treatment and there is no residential treatment centre in Limerick city or council which means they have to be referred and that is very difficult.

(Homeless service provider – Limerick)

Catchment areas can prove the main obstacle for homeless drug users wishing to access drug treatment in the Southern Health Board.

I just want to go back very briefly there, the catchment area, the catchment area is something that has caused us major problems, because whereas we are prepared to accept people from all parts of the country and still are, what is restricting us is in the recent cutbacks in the last six months or so, the Southern Health Board will only cover those in the Southern Health Board catchment area.

(Drug service provider – Cork)

Some of those working in residential drug treatment felt that this was because too much emphasis and resources are put into methadone maintenance in Ireland.

Can I just say that there is not enough emphasis put on detoxing, stabilisation and being clean – whether you will agree with me or not. I just feel that all the money has gone to methadone clinics.

(Residential worker – Dublin)

Most service providers agreed that usually the length of time between an initial assessment for drug treatment and getting a place was too long and these delays put homeless drug users at increased risk.

Often by the time their name comes up on the list the amount of drugs that they are using has escalated so it could be a whole different story.

(Drug service provider – Dublin)

But it is hard to get young people in. Not even so much from the service provision point of view but also what we were talking about earlier on – young people find it hard to hold appointments anyway but for a problematic, chaotic drug user keeping that appointment is the last thing on the list. There's benzos, gear and methadone to be got in the first place so in that sense it can be very hard to get young people involved – it can take anything up to two-and-a-half years of smoking heroin to finally realise that you are addicted to it.

(Homeless service provider – under 18s – Dublin)

It was reported that homeless drug users that do access residential treatment, sometimes find it difficult to comply with the routine and structure of a treatment programme.

At some level they are – if they don't have a structure and they come into residential – you know sitting at table is difficult, doing routine things can be difficult, but that can be difficult for a regular drug user or teenager doing these things.

(Drug service provider – Dublin)

I sometimes wonder about it because if they are very battered and bruised from their experience of life I don't know if they have the coping skills for that type of programme or not.

(Drug service provider – Limerick)

Subsequently, many service providers complained that treatment programmes in Ireland placed too many demands on homeless drug users and their relapse policies are not flexible enough.

I know it is not just a black-and-white issue like if you get caught once you are out, but when you get them back they lose their residential bed because of slip-ups and I find it very hard to get them back.

(Service provider – under 18s – Dublin)

There are gaps certainly. What happens with relapsers etc. There are a lot of places that will only give people one bite of the cherry as you were saying.

(Drug service provider – Cork)

Service providers noted that many homeless drug users were polydrug users and were using a range of drugs. However, drug treatment services in Ireland are still geared towards heroin use.

Opiate detox is meaningful in an environment where opiates are the main drugs of use, it is relatively meaningless in a context where alcohol use is heavy, concomitant as it is with cocaine using, daily hash smoking. I have a fair load of unstable people, so the thing is that a methadone dose tends to be a public official measure of how you are doing.

(Prescribing GP – Dublin)

But you are dealing with a lot of other issues as well – the obvious routes for heroin – there's benzos etc. That's when it gets really messy because there is no sure way to deal with that kind of thing.

(Residential worker – Dublin)

Overall, residential and detox programmes in Ireland were deemed unsuitable for homeless clients. This respondent's opinion was typical of many:

By getting somebody drug free a lot of the time it is just a fallacy, it doesn't happen. Our success rate is absolutely atrocious. The people who do detoxes and who stay clean are the ones who got through the net – it happened and we don't know how it happened. The ones who do it are the ones who have the family support, have the home to go back to, have the job maybe. They are the ones who do it, we are suitable for those sorts of people but for the homeless people the odds are stacked against them.

(Residential worker – Dublin)

Aftercare

The lack of aftercare following treatment was discussed at length by participants in the focus groups. Service providers felt that homeless drug users were set up to fail treatment programmes if they did not have accommodation secured following treatment. The consequences are that homeless drug users return to hostels that are not conducive to a drug-free lifestyle.

Following on then is if you have got somebody into a detox bed the next step is where do they go to after that – we have no dry houses [...] They end up back to the same situation where they started.

(Drug service provider – Cork)

Consequently most homeless drug users fear leaving any type of residential drug treatment.

Our clients, who are homeless, are so much easier to deal with because they are so relieved to have a roof over their head – they absolutely love the structure – they get fed – they don't have to think about it – they have a bed – they have a space. They love it – it is just a comfort zone. A lot of people get so used to it they just don't want to leave. We are kind of pushing them out the door saying "you have done what you came to do, you need to go now".

(Drug service provider – Dublin)

Successes

According to most respondents, any success or achievements were based on the commitment and drive of competent staff:

Interviewer: What would you say are the strengths of service provision for homeless drug users?

Respondent 1: Good workers.

Respondent 2: We do all we can for them. We're never off the phones trying to get them somewhere and they know that.

Respondent 3: Strengths I can think of – there are some good workers out there. Most community places have at least two or three good workers that I can think of who are really into their work. They go through heaven and hell for their clients to try and get them somewhere. In very difficult circumstances, I think that is strength. I cannot think of any other strengths.

(Drug service providers – Dublin)

Drug service providers in Galway felt that incorporating counselling with methadone prescribing had been a success.

The people I have been dealing with who do go to the methadone clinic here – they all see an addiction counsellor as well. It's the Outreach Addiction Service and they are very good – they just have a massive case load. They do deal with those people that have sort of failed in every sense with us and have been asked to leave. The great thing is – I've seen that most of those counsellors really click with their clients. The good thing is that those people or most of the people who use methadone are connected to addiction counsellors.

(Drug service provider – Galway)

In Limerick drug services had been successful in accessing funding for treatment for homeless drug users.

There is funding allocated to those that are homeless who want to access treatment – so we were able to pay for four or five people this year that had a homeless element or that were at risk of becoming homeless because of their drug use and getting them into treatment. That is a good thing.

(Drug service provider – Limerick)

Service Development

Similar to homeless services, drug service providers felt they could only provide appropriate services to homeless drug users with sufficient funding and appropriately trained staff.

We need appropriate and adequate resources to be able to meet their needs.

(Drug service provider – Limerick)

Staff need to be adequately trained in the broader sense to be aware and supportive. If staff are aware that there is a human being in front of them with x, y or z needs and you do whatever you can – if you do that in a respectable way and hear what the person has to say – there are limits as to what you can do but that's what makes a difference.

(Drug service provider – Limerick)

Many service providers also felt that any type of service provided to homeless drug users should incorporate some form of counselling and adopt an holistic approach.

They need perhaps counselling or something like that to overcome situations in their lives. A lot of these people are very young really – when you think of homeless you think of older people but a lot of them are very young [...] a lot of time it is centred around their addiction – it would be great if we could think of ways of encouraging them to take the next step out or whatever.

(Drug service provider – Limerick)

Low Threshold Services

Some service providers felt that consideration should be given to the establishment of a safe injecting facility in Dublin to help reduce the levels of public drug taking as well as offering homeless drug users a safe environment in which to inject.

I know there will be a great deal of objection to it but I feel a safe environment where a person can go, with the nurse, with the doctor, where they can inject and dispose of their needles safely would be a very, very valuable thing in the city centre – or even a mobile shooting gallery.

(Night shelter worker – Dublin)

We need consumption rooms. We have the guards coming along – we have security coming along – moving them. They're gone for a day but they're gone to another area. They're not stopping using. They're just leaving a mess somewhere else. So they need somewhere where they can use. Properly supervised place. A few good nurses there. Somewhere maybe they can have showers etc. It's badly needed.

(Drug service provider – Dublin)

Furthermore, drug services providers in Galway and Limerick feel that needle exchanges should be piloted in different locations in these areas:

They should be able to go into their local pharmacy [for a needle exchange] or link in with an outreach service. They should have choice. However, needle exchanges need systems and structures in place and staff need to be safe.

(Drug service provider – Limerick)

Methadone Treatment Programmes

Service providers advocated that any developments in methadone treatment for homeless drug users should be flexible, take a holistic approach and assist homeless drug users to access accommodation.

It should have been obvious that there was going to be a need for mobile dispensing services or at least a flexible network which included buses – the Amsterdam solution – that would be at least guaranteeing the minimum of civilised dispensing to persons irrespective of their location at some convenient time.

(Drug service provider – Dublin)

A lot of people come through our doors that would be on methadone. To get accommodation it is very hard because Dublin Corporation don't house people on methadone. There are lots of people on methadone that you would not even know are on methadone. People on methadone need to be sustained, so there should be a lot more transition for people on methadone.

(Settlement worker – Dublin)

But I think at this stage there should be more being done to take on board the clients' needs – their practical needs, their social needs over and above their methadone treatment.

(Pharmacist – Dublin)

Although methadone maintenance is not available in Cork, some service providers felt it should be considered as part of a more comprehensive drug treatment programme.

If there was methadone available as part of some rehab programme there would certainly be a lot more people on it, so knowing the service is not available is like a deterrent in itself.

(Drug service provider – Cork)

I think methadone is only one very specific treatment so supplying methadone is not the answer – it needs to be a whole comprehensive plan whereas methadone might be one of those solutions but it cannot be used in isolation.

(Homeless service provider – Cork)

Treatment

As service providers felt that homeless people found it difficult to follow existing treatment programmes, it was recommended that programmes are designed which are more accessible, more flexible and less structured.

It can be months to get an appointment; it needs to be fast tracked and easier access.

(Drug service provider – Cork)

Finding suitable accommodation for homeless drug users is probably the most crucial step in preventing relapse and service providers felt that this should be incorporated into treatment programmes.

At around the three-month mark of an individual's programme we would be looking at accommodation, where they want to live, what sort of services we would need to link into to secure some kind of accommodation and the suitability of that accommodation would probably be an issue in terms of their recovery.

(Drug service provider – Dublin)

Given the difficulties homeless drug users experience in accessing treatment, service providers recommended the need for respite care.

They need a kind of care prior to doing a rehab programme if you like, and they need some place where they can go in and get respite first of all, maybe on detox if that is needed [...]. Some might do a rehabilitation programme, other people might want to go into re-settlement straight away. Try to help those kind of people who get lost, they don't have access to a lot of the services.

(Drug service provider – Cork)

[There's a place in London] – if you are really bad you will be taken in there – you can stay for a maximum of three weeks – in that time you get three meals a day – you get a bed and you get a counsellor in there if you want one who will work through issues with you. If you want to go back out onto the street that is grand – they will put you back out onto the street. If you don't and you want to go on to residential they will have a hotline on to every residential in England and they will fast track you through into residential.

(Drug service provider – Dublin)

Aftercare

Service providers highlighted the need for more aftercare addressing housing, retraining, employment and social support.

You have to try and arrange accommodation yourself and that is determined by what is available from the Corporation, Council etc. There is very, very little available. Sometimes it is interesting that what is available in the short term would be most unsuitable. If there was accommodation available it would be in some areas that you would want to avoid.

(Drug service provider – Cork)

I would like to see sheltered housing where they get used to living by themselves, get your things together, get your bit of work or your training and you are ready to move.

(Drug service provider – Dublin)

8.6 Contact with Generic Services

All respondents were asked about their level of contact with various generic services. GP services were the most cited service contact which was reported by over a half of respondents (n=201; 57%). Over a third of those who reported contact with GPs were problematic drug users (n = 75, 37%), of whom only 29% (n = 22) were currently receiving methadone. A substantial number of individuals (n=150; 43%) reported contact with community welfare officers over the three-month period prior to interview, while over a quarter (n=97; 28%) reported contact with Gardaí. Twenty-seven percent (n=94) had contact with hospital clinics and nearly one-in-four respondents had contact with A&E departments (n=79; 23%). Contact with local authority offices and social workers was reported by 26% (n=90) and 25% (n=88) of respondents respectively. Sixteen percent of the total study population (n=58) had contact with either a psychiatric clinic or community psychiatric nurse in the three months prior to interview.

8.7 Assessment of Service Needs

All individuals were asked to subjectively state whether they required any of the listed service needs. Multiple responses were allowed. As conveyed in Table 8.6, the majority of respondents across all city locations reported stable accommodation as their primary service need.

Training and employment opportunities were the second most cited service need. Access to health care services was reported by over a quarter of the total study population (n=102; 29%) with more than one-in-three of the Dublin sample reporting the need for health care services. This is considered high in view of recent developments (such as; primary health care teams; “fast-track” medical card system etc.) which have sought to facilitate access to, and delivery of health care services for the Dublin homeless population. Just over one-in-four of the total study population reported the need for social support mechanisms, and one-in-three of the Dublin sample.

Twenty-four percent (n=83) of the total study population reported drug and/or alcohol treatment as a service need. This is also relatively high in view of the fact that 36% (n=127) of the total sample scored as problematic drug users according to the DAST screening instrument. Twenty-nine percent (n=16) of rough sleepers reported that they required drug/alcohol treatment in comparison to only 23% of both hostel dwellers (n=39) and B&B occupants (n=16).

The need for drug and alcohol treatment was also reported by over a quarter of the Dublin sample (n=69; 28%). Outside Dublin, just over a fifth of the Galway sample reported requiring drug and alcohol treatment, in comparison to 14% for Cork (n=5) and 3% for Limerick (n=1).

Table 8.1 Self-Reported Service Needs by City Location

Service Need	Total Study Population		City Locations							
	(n=355)		Dublin (n=247)		Cork (n=36)		Limerick (n=36)		Galway (n=36)	
	%	n	%	n	%	n	%	n	%	n
Stable Accommodation	86	[302]	89	[216]	89	[31]	56	[20]	97	[35]
Training/ Employment	39	[135]	42	[101]	40	[14]	19	[7]	36	[13]
Health Care	29	[102]	34	[83]	20	[7]	3	[1]	31	[11]
Social Support	27	[96]	34	[83]	6	[2]	3	[1]	28	[10]
Drug/Alcohol Treatment	24	[83]	28	[69]	14	[5]	3	[1]	22	[8]
Legal	20	[70]	25	[60]	14	[5]	-	-	14	[5]
Emergency Accom.	17	[59]	18	[44]	3	[1]	3	[1]	36	[13]
Psychiatric Treatment	14	[50]	16	[38]	9	[3]	-	-	25	[9]
Other*	5	[14]	3	[7]	3	[1]	17	[6]	-	-

* "Other" service needs reported were; access to children/custody (n=3), caravan (n=2), rented accommodation (n=1), budgeting advice (n=1), hygiene (n=1), food and washing facilities (n=1), "unforced" drug and alcohol treatment (n=1), clothes (n=1), home help (n=1), parenting skills (n=1), stability (n=1).

8.8 Summary and Conclusions

- **There were high levels of contact reported with emergency accommodation, drop-in centres and food services. Very few respondents cited the absence of drug/alcohol users as a factor influencing use of homeless services (3% and 1% respectively).**

While accessing accommodation can be problematic for all homeless people, it is particularly difficult for certain groups, such as young people, families, drug users and those with mental health problems (Corr, 2003c). Contact with services are highly influenced by personal characteristics of service users and service delivery factors and availability (Warnes et al., 2003). Fountain and Howes (2001) found in their sample of rough sleepers that the longer respondents had been homeless, the more likely they were to have used services for homeless people. Fountain et al. (2002) also found that the uptake of homeless services was far higher than it was of drug and alcohol services.

- **In relation to contact with homeless services, the results would indicate that problematic drug users, and to a lesser degree, problematic drinkers, were more likely to have problems accessing homeless services and more likely to be refused access to homeless services.**

Kennedy *et al.* (2001:22) refers to a substantial body of literature which has documented that homeless people and drug users frequently encounter difficulties accessing services. Furthermore, one possible explanation provided is a failure of drug and homeless services to work effectively together (Kennedy *et al.*, 2001). Furthermore, a service often responds very differently to a person who is primarily a drug user than to another homeless person (Fountain *et al.*, 2002).

- **Few of the homeless services interviewed had official policies on illicit drug use, possession and dealing. All agencies interviewed did not allow drug use or drug dealing on the premises but policies around drug-related incidents were more flexible.**

Flemen (1999:31) argues that when formulating drug policies homeless services should not be concerned solely with “what is and is not legal” but rather should be part of a more extensive organisational management approach. Organisational policies can only be offered as a framework in which it may be necessary to make judgments on the basis of the known procedures and policies. It is also necessary to ensure that any details included within an organisational policy are not in any manner contradictory to service users rights or overall ethos of the organisation (Britton and Pamneja, 2000).

- **Many of the challenges faced by homeless service providers working with homeless drug users include detecting and recognising drug use, being able to deal with a number of issues simultaneously, addressing their own preconceptions of homeless drug users, fear of dealing with death by overdose, protecting staff and client safety and motivating drug users to address their drug use.**

Similarly research carried out in Britain found that working with homeless drug users was particularly challenging which often meant that some homeless agencies were reluctant to work with the target group (Flemen, 1999; Kennedy *et al.*, 2001).

- **The general perception among service providers was that homeless services do not adequately meet the needs of homeless drugs users. Barriers faced by homeless services included lack of knowledge and training around drug issues, lack of experience and the negative attitude of some staff towards drug users, lack of resources and funding restrictions, alienating clients by adopting an abstinence-oriented rather than harm reduction approach and no day service specifically targeted at homeless drug users. In relation to accommodation, service providers questioned the quality of these services for homeless drug users and highlighted the lack of move-on options from emergency accommodation.**

This supports international literature which indicates that a growing demand is being placed on homeless services by drug users. The capacity of homeless services to deal with homeless drug users is been challenged by not only the complexity of their needs but also organisational limitations, such as training and adequate resource allocation.

- **Reference was often made to some homeless service environments not being conducive to an ex-user wishing to sustain a drug-free lifestyle. The majority of service providers interviewed felt that specialist services were the most appropriate for homeless drug users, particularly in relation to accommodation. Moreover, they emphasised that any specialist service needed to provide appropriate harm reduction services.**

It is argued that generalist provision of homeless services can often ill equip people with multiple needs (Fountain *et al.*, 2002). Randall and Brown (2002a) argue that specialist substance misuse workers working on the streets and in hostels are better able to negotiate access to services and treatment programmes than non-specialists. Best practice literature in the area suggests that specialist accommodation is central to the provision of services for homeless drug users (London Drug Policy Forum, 1999; Randall and Drugscope, 2001).

- **According to homeless service providers, successful ways of engaging with homeless drug users, which could be built on, included focusing on individuals' behaviour rather than drug use, remaining flexible and promoting multi-disciplinary work. Service providers also recommended that services could be developed in the following ways: increases in resources and funding; development of a continuum of care and settlement plan for homeless drug users; exploration of the feasibility of a safe injecting room; provision of a range of accommodation options including move-on accommodation for drug users in emergency accommodation; additional transitional housing; long-term stable accommodation (through local authorities and private rented); and half way houses.**

Neale (2002) revealed that good practice in working with homeless drug users related to five broad areas. These were: staffing, agency environment, support provided, service delivery and agency aims and objectives.

- **Just over a third of the homeless population reported contact with a drug service within the previous three months (36%). Contact with drop-in centres and methadone treatment services were relatively high, reported by one-in-two of those who reported drug service contact. Eighty-five percent of current injectors were in contact with a needle exchange within the preceding three months, representing 17% of the total homeless population.** Houghton and Hickey (2001) found that 40% of respondents were in contact with addiction services at the time of interview and 48% in the three months previously. The study findings reiterate those of Fountain *et al.* (2003:387) which noted that "while drug use and dependence of the sample was high, the uptake of drug services by those in need of them was low". Syringe exchanges are effective in attracting drug users into services. Forty-eight percent of first time attendees at the Merchants Quay Ireland syringe exchange had never previously been in contact with any drug service (Cox and Lawless, 2000). However, the influence of syringe exchanges upon risk behaviour is likely to be affected by local conditions of availability of equipment, the profile of injectors, educational strategies and the user-friendliness of services (Friedman *et al.* 1992).
- **During the focus groups, no drug services interviewed reported having a policy on how to deal with homeless clients.**
- **The main challenges drug service providers reported in working with homeless drug users was trying to meet their multiple needs, engaging with those who did not want to give up drugs, while those working within the confines of an abstinence-oriented model (mainly in Cork and Galway) found it frustrating.**
- **According to service providers the quality of drug services offered to homeless drug users was often poor and under-resourced and short-staffed. The lack of needle exchanges in Galway and Limerick and the absence of needle exchanges in the evening and at weekends in Dublin were highlighted as serious gaps in service provision. According to drug service**

providers, difficulties homeless drug users had in accessing methadone maintenance treatment included lack of permanent address, waiting lists, keeping appointments, harsh sanctioning for failing urinalysis and the problems in having to attend methadone clinics daily. In relation to treatment, drug service providers felt that there were not enough detox and residential places, the delay between initial assessment and drug treatment put homeless people at risk and the routine and structure of treatment programmes often did not suit homeless drug users. Furthermore, the lack of aftercare meant that homeless drug users were often set up to fail.

- Drug service providers recommended the need for sufficient funding and appropriately trained staff in order to meet the needs of homeless drug users. Some service providers in Dublin highlighted the need for a safe injecting room, while those in Galway and Limerick felt needle exchanges should be piloted in different locations in these areas. Service providers advocated that methadone maintenance and treatment programmes should be flexible, less structured, take an holistic approach and assist homeless drug users to access accommodation. Some service providers in Cork and Dublin expressed a need for respite care for homeless drug users as well as aftercare addressing housing, retraining, employment and social support.

- Despite high levels of contact with GPs, hospital clinics, and A&E departments, almost one-in-three homeless individuals reported health care as a service need. Half of those who reported contact with a GP were problematic drug users (n=99; 55%).

Evidence has shown that homeless people experience difficulties in accessing mainstream health services (Bines, 1994; Pleace and Quilgars, 1996; Holohan, 1997; Wright, 2002). Of greater importance, is the fact that many homeless individuals find health services inappropriate or ill-equipped to meet their needs (Wright, 2002). Moore *et al.* (1997) found that many health problems associated with homelessness might be due to the limited use of health services which are often inaccessible, unacceptable and inappropriate. Similarly, drug users can experience lack of access to appropriate health services due to their drug-using status. Medical visits among drug users are often reactive to situations rather than on a routinely health care basis (Lawless, 2003). Factors which can influence general practitioners negative attitudes of drug users may be the lack of the perceived skill or training to deal with this client group, or even concerns regarding their own personal safety (Greenwood, 1992).

- Stable accommodation was reported as the primary service need among respondents (86%). One-in-four respondents reported drug or alcohol treatment as a service need (24%), increasing to 28% within the Dublin sample. Higher numbers of rough sleepers (29%) reported requiring drug/alcohol treatment than hostel dwellers or B&B occupants (23% respectively).

In a study of rough sleepers in the UK, over a half of the current drug users (52%) and a third (33%) of current alcohol users stated that they required help with their substance use, but few were currently accessing the appropriate services, other than needle exchanges (Fountain *et al.*, 2003: 377). Fountain *et al.* (2003) state that a discrepancy can exist between the drug user's need and drug service uptake among homeless drug users. Individuals may not want to approach drug services for fear of being labelled as a drug user or disclosure of practices and the possible repercussions on their accommodation (Flemen, 1999). The above figures for alcohol treatment as a service need among rough sleepers are consistent with Fountain *et al.* (2003), however lower rates of need were observed for drug treatment among rough sleepers.

Chapter Nine

Conclusions and Policy Implications

9.1 Conclusions

This is the first Irish study undertaken which examines the nature, extent and context of drug use among the homeless population. The information contained within this report provides a strong empirical base upon which to develop services and implement future policies.

1. This study has highlighted that the causes of homelessness are complex and include both individual/personal and societal/structural factors. For many, drug use was initiated prior to becoming homeless, while for the minority, drug use emerged as a feature of their homeless predicament. To argue that drug use causes homelessness reduces the complexity of the relationship and simplifies it to merely a cause and effect process with no intervening variables. Reasons for becoming homeless and reasons for remaining homeless were not always a result of the same phenomena. Members of the homeless population cited a number of personal reasons for becoming homeless (e.g. family conflict, alcohol use, drug use), while reasons for remaining homeless were largely structural factors related to barriers in accessing housing in Ireland (e.g. length of time on waiting list, difficulties regarding the private rented sector etc.). Drug use was the second most commonly cited reason for becoming homeless. Alcohol was also a contributing cause of homelessness. Main reasons for homelessness refer only to the first experience of homelessness and factors associated with subsequent episodes may therefore have altered. Women were more likely than their male counterparts to have more experiences of homelessness. This would suggest that specific triggers for homelessness exist for women which has implications for their security of tenure and highlights an exploration into various intervention strategies which are sensitive to the needs of homeless women and homeless women with children.
2. Those experiencing homelessness are an extremely heterogeneous population. This heterogeneity includes demographics, pathways into, and experiences of, homelessness, in addition to a number of complex and interacting service needs. Most commonly, these include drug and alcohol use, mental health issues, dual diagnosis, poor physical health and experience of blood-borne infections. The presence of multiple needs means that individuals are often chaotic and vulnerable and require a multi-disciplinary approach to address their needs. Although the vast majority of service providers reported that they worked with people with multiple needs, service systems were often reported to respond in a one-dimensional manner. The ability and capacity of those working with this group is challenged by the lack of appropriate resources, training, co-ordination of services and overall integrated structures.
3. High levels of licit (including alcohol) and illicit drug use were reported among the homeless population with regional differences in drug-use patterns and experiences. Alcohol remains the current drug of choice among the homeless population, with older males reporting the highest frequency of use. Those staying in squats and sleeping rough also reported a higher frequency of alcohol consumption. Almost three-in-four current drinkers scored as problematic, representing over half of the total homeless population. Homeless males reported a higher level of alcohol problems than female respondents. Those staying in hostels exhibited the highest proportion of problematic drinkers (55%), followed closely by rough sleepers (52%). Nearly two-fifths of B&B occupants exhibited problematic drinking (39%).

4. Moreover, the research supports the hypothesis that the extent of illicit drug use among the homeless population is substantially higher than it is among the general Irish population. Cannabis is the most commonly used illicit drug. The use of opiates among the homeless population was mainly confined to the Dublin Area. Similarly, drug treatment services in the Dublin Area focus mainly on opiate use. This was highly evident in terms of drug substitution programmes where all current users of methadone were from the Dublin homeless sample. Homeless drug users also had a tendency towards polydrug use (i.e. they use more than one drug) (excluding alcohol). A high frequency of use of prescribed medication was reported by respondents. There were high levels of intravenous drug use reported among the Dublin homeless population.
5. This research has highlighted the importance of lifestyle factors, i.e. appropriate housing among drug users and the impact of their housing arrangements in patterns of risk behaviour. The circumstances in which drug use and drug injecting among the homeless took place were over and above those of personal choice or motivation. Injecting drugs in the streets and other public places was increasingly common among homeless injectors and was often the only viable option for those interviewed. It is interesting to note that over two-thirds of those who injected at their place of residence were B&B occupants. As women and children tend to characterise the profile of this accommodation type, their injecting practices tended to occur in private rather than exposed areas.

Homelessness was clearly related to a worsening drugs situation. The issue is not that people start to use when they become homeless but their practices and behaviour become more 'risky'. In terms of risk behaviour, drug use and homelessness are clearly interrelated, complicating and exacerbating one another. The social context of injecting practices among the homeless was also more likely to involve contact with other injectors. Over half of injectors reported injecting with others, either with their partner or in a group. Female injectors were less likely to report injecting themselves and as such were more likely than male injectors to report communal injecting practices. Homeless injectors exhibited extremely high levels of injecting risk behaviour (i.e. within last three months), most notably the borrowing of used injecting equipment and the sharing of injecting paraphernalia. The "situational sharing" of injecting equipment and paraphernalia was obvious from individual quotes. Such activities have demonstrated the implications for individual risk behaviour and health concerns with over half of problematic drug users reporting a positive hepatitis C status. The low numbers of problematic drug users who were currently receiving treatment for hepatitis C (11%) must be seen within a context where accessing hepatitis C treatment can be onerous for individuals in terms of stabilising their drug use.

6. Survey data from those experiencing homelessness, and information from service providers, substantiate that homeless drug users have numerous complex needs that are not being sufficiently met by existing services. Problematic drinkers were significantly more likely, and problematic drug users were proportionally more likely, to report psychiatric concerns. B&B occupants exceeded hostel dwellers and rough sleepers in terms of ever being diagnosed with a psychiatric illness. Similarly, B&B occupants scored the highest level of drug dependency (36%). These findings are particularly interesting given their profile as largely women with children which would highlight implications for service delivery and identifying appropriate interventions. It is not possible to assume that psychiatric illness or drug use is confined to single adults and responses therefore have to recognise the different family types affected.

Many homeless service providers reported continual increases in the number of drug users accessing their services. Homeless service staff felt ill-equipped to deal with the complexity of the issues presented by this group. Some homeless service providers felt that they did not have the resources or expertise to deal with this client group. Some homeless service providers felt homeless drug users were a difficult and challenging group to work with and these myths serve only to reinforce the idea of the deserving and non-deserving homeless people and such attitudes can often inform service providers' working practices.

All accommodation providers interviewed operated a "no-drugs" policy. The existence and operation of a "no-drugs policy" was reported to be largely dictated by the law covering possession, use and supply. Although drug policies can demonstrate a clear understanding of services' position and the necessary procedures to be followed should a problem arise, in some instances a "no-drugs policy" was interpreted by services as providing justification for a "no drug-user" policy. Some emergency accommodation providers did accept homeless drug users, as long as they complied with the policies, while others refused to accept active drug users. This often led to drug users concealing their use and this often meant that their drug use went undetected. This highlights the failure among some accommodation service providers to acknowledge that a substantial proportion of their clients use drugs. Homeless drug users, did to a greater extent have access to daytime care services.

7. While drug use can act as a barrier to housing services, so too can homelessness act as a barrier to drug services. Homeless drug users who seek treatment options were regarded as "high risk" as many drug service providers reported that it is more difficult to retain clients in treatment, keep appointments and meet the demands of a structured programme.

Homeless drug users cannot be managed within the services and policies of the past. Although both service users and service providers noted the need for additional and more diverse services, there was also an emphasis on focusing and reviewing the current type of interventions which are made with homeless drug users. For example, homeless service providers highlighted the fact that there were "limited services beyond emergency crisis provision" and that preventative interventions in specific areas and move-on options, provide the means for which settlement is a possibility. These expectations are in line with the key activities proposed within the action plan on homelessness for Dublin 2004-2006 in which it states that there will be "a shift in service delivery, away from making people fit into the services available towards making the services suitable" (Homeless Agency, 2004: 3).

Based on the findings of the study, the following conclusions are warranted:

- Drug use and homelessness are clearly interlinked.
- Drug use amongst homeless individuals occurs at much higher levels than among the general population.
- Drug use among the homeless population ranges from those who consume drugs in an experimental and recreational way to those who are problematic and dependent users.
- Alcohol is the current drug of choice among the homeless population.
- Cannabis is the primary illicit drug of use for the homeless population.

- There is a high level of consumption and problematic use of alcohol among the homeless population.
- There is a high level of problematic and dependent drug use amongst homeless people.
- Drug use among those experiencing homelessness has regional variations by drug type and level of use.
- Problematic and dependent opiate use is a serious issue among those experiencing homelessness in Dublin.
- Problematic and dependent alcohol use is the main issue among homeless people outside of Dublin.
- Drug use among those who are homeless varies by homeless accommodation type.
- Higher levels of problematic drug use is found among rough sleepers than among those staying in hostel or B&B accommodation.
- Drug-using homeless individuals in hostels use drugs at less dependent rates than those staying in B&B accommodation or sleeping rough.
- Polydrug use is a characteristic of the homeless drug-using population.
- Homelessness is a predictor of drug-related risk behaviour.
- Injecting risk behaviours (such as needle sharing, difficulties injecting, precarious injecting sites and practices) are high among the homeless population.
- Drug-using homeless individuals have very complex and interrelated needs including mental health issues.
- Drug-using homeless individuals are often excluded from homeless services by virtue of their drug-using status.
- Employing policies to exclude drug-using people from homeless services probably does impact but does not prevent drug users accessing services and can undermine efforts to minimise drug-related harm.
- Homeless drug users have inadequate access to, and use of, drug services.
- There is inadequate consideration of the needs of this drug-using population group in the development of drug treatment services.
- Services are clearly defined in relation to areas of expertise and, as such, gaps in service provision emerge.
- Services (drug and homeless) have ultimately failed to respond to this issue as an organisational priority.

9.2 Policy Implications

The research findings have particular implications for policy development and areas for consideration are presented herein.

1. The National Drugs Strategy (2001-2008) emphasises an approach to tackling drug problems in Ireland whereby partnerships between key agencies including health, social services, education and criminal justice agencies are seen as being crucial to the success of the strategy. The delivery of high-quality effective treatment for all drug users is dependent on co-ordination of services and is fundamental to the success of the Government's drug strategy. The findings of the study highlight that there are issues regarding co-ordination of drugs and homeless services and joint working relationships between statutory and non-statutory agencies. Results convey that a feature of existing service responses has been the lack of awareness regarding where the responsibility for this client group lies. It is important to ensure a more strategic approach with clear lines of responsibility and accountability for those working with drug-using homeless individuals.
 - The National Drugs Strategy Team and the Homeless Agency are beginning to work together, to develop and establish joint strategies which would have clear links with the National Drugs Strategy and Homeless Strategy and would also involve the local authorities and health boards. A representative of the Team has been appointed to the expanded Consultative Forum of the Homeless Agency.
 - At a local level, consideration should be given towards providing a means through which drug services would have an input in local homeless action plans and for those working in homeless services to be represented on local/regional drug task forces.
 - The adoption of integrated care planning and management would help combine and co-ordinate different services and interventions which are required to meet the needs of homeless drug users. It would require partnership working between drug and homeless services to ensure that the appropriate service is available for the individual at the stage when it is required. Currently, the Homeless Agency has developed care management proposals to be applied to the homeless sector and supported by Care Managers and the Dublin Link system.
2. Homelessness is the sharp end of exclusion (Seddon, 1998). Lack of stable housing can often mean exclusion from other essential services. It is important that homeless services take an inclusive approach to drug users rather than excluding them from some of their services. Drug use is not solely an issue for drug service providers. Homeless drug users do and will access homeless services.
 - Given the multiple needs of homeless people and homeless drug users in particular, there is a need for a continuum of care in relation to accommodation provision (ranging from harm reduction-oriented services to drug-and-alcohol-free environments).
 - Some homeless services already offer low-threshold drug services and other harm reduction techniques. However, it is also important that homeless services engage with drug services and ensure that these individuals are linked into mainstream drug service provision.
 - The issue of dual diagnosis has been highlighted as creating difficulties for homeless services. Homeless service providers are unsure of the appropriate referral means for psychiatric care for drug-using service users. Part of the problem in resolving such difficulties is the highly medicalised

focus of mental health and drug services (Homeless Agency, 2001:140). The development of dual diagnosis services which would integrate homeless services with mental health and drug/alcohol specialists would be welcomed.

- There is an issue around the level of knowledge among homeless services in regards to management of drug use and drug service provision. It would be beneficial if drug awareness training was provided to all staff in homeless services. Homeless services should review the role and possibilities of specialised drug workers in services. Good practice as identified by Randall and Drugscope (2002) is that specialist drug workers should train staff in using drug screening tools.
3. The issue of homelessness among drug users has implications for current delivery and management of drug services. It is important to increase the availability, capacity and effectiveness of drug treatment for homeless persons in Ireland. The findings suggest that drug service and practice could be enhanced to address the multiplicity of issues within this group.
- A broad range of accessible, appropriate and adequate drug services should be targeted at homeless individuals who are current, problematic or dependent drug users as well as those who are making a transition to a drug-free lifestyle.
 - Consideration should be given towards the development of more targeted treatment practices for this client group, such as, care-planned counselling, flexible methadone-prescribing options, elimination of waiting lists and time intervals between assessment and entry into treatment as well as less structured programmes with fewer demands.
 - Consideration should be given towards the establishment of satellite drug services within homeless agencies (for e.g. day services, hostels) which would seek to increase accessibility by locating services within an already familiar environment. Liaison services should be an integral part of the satellite site linking into a broader range of drug services.
 - Increased coverage of drug outreach services to homeless drugs users staying in hostels would enhance referral and support mechanisms and facilitate access to mainstream services. Consideration should be given to the development of peer education and community change programmes aimed at changing norms and behaviour among social networks of homeless drug injectors, such as rough sleepers.
4. It is important that homeless drug users can not only access treatment, but that the treatment is effective and linked into appropriate aftercare support and housing. It is necessary to approach the treatment of homeless people in a multi-disciplinary, holistic, flexible and non-judgmental way.
- A continuum of care model should ensure a clear treatment route for homeless drug users which takes into account pathways in and out of homelessness and mobilisation across homeless accommodation types. This may include; motivational interventions, active, intensive ongoing support, as well as practical measures to encourage attendance and engagement.
 - Pre-treatment services for homeless people with drug and alcohol problems would help with the process of engaging in drug treatment, by determining the readiness of the individual, offering support around meeting treatment entry criteria, stabilising/reducing drug use and sustaining motivation.

- There is a need to place greater importance on discharge practices and follow-up care following drug treatment (in particular detoxification and rehabilitation programmes) to ensure a more planned transition to drug-free independent living for homeless drug users. Housing needs assessment is an integral part of the treatment process, in addition to methods of establishing and maintaining aftercare support networks.
5. Harm reduction strategies are a key feature of the extensive measures which attempt to tackle the drugs issue in Ireland. This study has conveyed the importance of a broad-based harm reduction approach which includes treatment, accommodation, support and training options. Drug use cannot be isolated from the social context in which it occurs. The importance of the 'setting' (i.e. environmental or contextual factors) in which an individual's drug use takes place is seen as central (Zinberg, 1984). When the setting is an environment where homelessness prevails, people are predisposed to a different and more risky style of drug use than would be commonplace among the general drug using population (Klee and Morris, 1995; Horn, 2001; Cox, 2000). In this regard, tailoring initiatives to the characteristics of target groups (Moore *et al.*, 2004:7) is foremost.
- Street-based risk-reduction strategies, which can minimise the precarious drug-using behaviour, need to be targeted at homeless individuals. Optimal needle exchange coverage and access for homeless injectors at a local, community and service level is essential. The issue of 24-hour access has particular relevance for homeless injectors and should be addressed (e.g. through pharmacies, outreach workers and other mobile services). Sharps bins should also be strategically placed in public areas and homeless services to ensure the safe disposal of injecting equipment.
 - Policy makers should give consideration as to the extent to which the provision of a supervised environment, such as a safe injecting facility, would adequately address the needs of homeless injectors, for example by allowing more hygienic injecting practices to occur and reduce street-based injecting and the experience of fatal overdoses.
 - There is a dearth of information regarding good-practice harm reduction strategies in relation to polydrug use. The high risk situation of polydrug use and interactions associated with different drugs in terms of potential health consequences would appear to be an area for further development.
 - Homeless drug users present with a range of needs. Therefore, consideration should be given to the provision of respite care for homeless drug users, in particular rough sleepers, which would provide a break from life on the streets and encourage them to address their difficulties.

6. Traditionally, services for homeless people who have alcohol-related problems have been dominated by abstinence models of intervention (Butler, 2003) with harm reduction being more commonly referred to in the context of illegal drugs. Harm reduction should be understood to include all substances both licit and illicit. Given the profile of homeless drug users, it is important that a targeted alcohol-harm reduction strategy for members of the homeless population is promoted. As with drug use, abstinence may be unacceptable as a goal for the homeless individual and in such cases, it is necessary to implement strategies which focus on moderation in use and reducing alcohol-related harm.
- It is important that the implementation of an updated National Alcohol Strategy takes account of the present situation in terms of alcohol-related harm and those who are most vulnerable. It is vital that there is an overarching objective or key proposals outlined for improving alcohol treatment and aftercare services for those experiencing homelessness.
 - The ERHA (2003) has highlighted the homeless population as a priority group in terms of health promotion in relation to alcohol use. To this end the SWAHB has funded an alcohol detox unit for homeless people managed by Dublin Simon Community. This research supports the development of similar initiatives targeted at the homeless population as well as developing other harm reduction services tailored to meet their needs.
 - Consideration should be given towards the establishment of a facility for street drinkers in Dublin that can offer an alternative to street drinking practices, for example, wet day centres. Wet day centres provide a first point-of referral and contact for those who are excluded or unable to use conventional or mainstream services. A wet day centre would give street drinkers a safe space in which to drink and be offered support when needed and referral to services which focus on harm reduction. The Rough Sleepers Unit in the UK (1999) stated that it is better to have *rough sleepers drinking inside where they can get help, rather than out on the street with no prospect of reaching them.*

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Appendix 1

Quantitative Survey Questionnaire – Homeless Population

Home Truths Research Project

Survey Questionnaire

Questionnaire No. *(office use only)* _____

Participant Identifier _____
(complete as appropriate e.g EL F 30041976) *(initials, gender, dob)*

Consent Form Signed *(tick as appropriate)* _____

Interviewer Code

Recruitment Site *(write in)* _____

Interview Location On Site
Elsewhere
(please specify) _____

Date of Interview d m y

Start Time of Interview _____

Finish Time of Interview _____

Section 1 – Demographics

Explain that this information is necessary in order to convey a profile of those who participate in the research study.

D01 What type of accommodation are you currently living in?

Don't read options

(Tick as Appropriate)

Hostel/Shelter

Name *(if possible)*

B&B

With Friends/Relatives

Sleeping Rough (streets/parks)

Squat

Other *(please specify)*

D02 How long have you been staying there?

Don't read options

(Tick as Appropriate)

A Few Days

A Few Weeks

A Few Months

More than 6 Months

A Year or More

Don't Know

D03 Where is the main place (4 nights or more) you have slept in the past week?

Don't read options

(Tick as Appropriate)

Hostel/Shelter

B&B

With Friends/Relatives

Sleeping Rough (streets/parks)

Squat

Other *(please specify)*

D04 Do you live in this accommodation?

Read options

(Tick as Appropriate)

- Alone
- Alone with children*
- Parents and Children*
- With partner

*Number of children under 18 _____

D05 Clients' Initials _____

D06 Gender

- 1. Male
- 2. Female

D07 Age

years

D08 Date of Birth

day month year

D09 Where are you from?

Don't read options

(Tick as Appropriate)

- | | |
|-------------------------------------|---|
| Ireland <input type="checkbox"/> | Northern Ireland <input type="checkbox"/> |
| UK England <input type="checkbox"/> | UK Scotland <input type="checkbox"/> |
| UK Wales <input type="checkbox"/> | Other EU <input type="checkbox"/> |
| Africa <input type="checkbox"/> | Asia <input type="checkbox"/> |
| USA <input type="checkbox"/> | Australia <input type="checkbox"/> |
| Other <input type="checkbox"/> | _____ |

D10 How would you describe your ethnic background?

(Tick as Appropriate)

- White
- Traveller
- Black
- Chinese
- Asian
- Mixed ethnic group
- Other ethnic group

Section 2 – Homelessness

State that this section will ask a few questions about the individual's experience of homelessness.

H01 Is this your first experience of being homeless? Yes No

If No

(A) How many times have you been homeless? times

(B) In your opinion, what would be the longest period you have spent homeless? Years Months

H02 In terms of your current spell, how long have you been homeless?

Years Months

H03 How old were you when you first became homeless?

(years)

H04 Where has been the (main place/other places) you have slept over the past month?

Don't read options

	Main Place <i>(One Response Only)</i>	Other Places <i>(Multiple Responses Allowed)</i>
Hostel/Shelter	<input type="checkbox"/>	<input type="checkbox"/>
B&B	<input type="checkbox"/>	<input type="checkbox"/>
With Friends/Relatives	<input type="checkbox"/>	<input type="checkbox"/>
Slept Rough	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>
Transitional Housing	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

H05 What do you think were (the main reason/other reasons) for you first becoming homeless?

Don't read options

Main Reason
(One Response Only)

Other Reasons
(Multiple Responses Allowed)

Family Conflict	<input type="checkbox"/>	<input type="checkbox"/>
Relationship Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Money Problems	<input type="checkbox"/>	<input type="checkbox"/>
Court Order/Notice to Quit	<input type="checkbox"/>	<input type="checkbox"/>
Told to Go by Landlord	<input type="checkbox"/>	<input type="checkbox"/>
Asked to Leave by Family	<input type="checkbox"/>	<input type="checkbox"/>
Evicted from Local Authority	<input type="checkbox"/>	<input type="checkbox"/>
Evicted from Private Rented	<input type="checkbox"/>	<input type="checkbox"/>
Pressure from Local Community	<input type="checkbox"/>	<input type="checkbox"/>
Evicted due to anti-social behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Unfit Accommodation	<input type="checkbox"/>	<input type="checkbox"/>
Overcrowded Accommodation	<input type="checkbox"/>	<input type="checkbox"/>
Leaving Institution/Prison (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use-Personal	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use-Family	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use-Personal	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use-Family	<input type="checkbox"/>	<input type="checkbox"/>
Physical Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
Mental/Psychiatric Issues-Personal	<input type="checkbox"/>	<input type="checkbox"/>
Mental/Psychiatric Issues-Family	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>
Physical/Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

H06 What do you think are the (main reason/other reasons) for you currently remaining homeless?

Don't read options

	Main Reason <i>(One Response Only)</i>	Other Reasons <i>(Multiple Responses Allowed)</i>
Cannot Access Housing-Local Authority	<input type="checkbox"/>	<input type="checkbox"/>
Cannot Access Housing-Private Rented	<input type="checkbox"/>	<input type="checkbox"/>
Local Authority Will Not Re-House	<input type="checkbox"/>	<input type="checkbox"/>
Money Problems	<input type="checkbox"/>	<input type="checkbox"/>
Family Conflict	<input type="checkbox"/>	<input type="checkbox"/>
Access Denied by Residents' Committee	<input type="checkbox"/>	<input type="checkbox"/>
Continuing Drug Use	<input type="checkbox"/>	<input type="checkbox"/>
Continuing Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Drug Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Alcohol Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Issues	<input type="checkbox"/>	<input type="checkbox"/>
Others Alcohol/Drug Use	<input type="checkbox"/>	<input type="checkbox"/>
Personal Choice	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

H07 Where was your last permanent address?

If in Dublin (Area or Postcode) _____

Outside Dublin (Town/City) _____

H08 Are you currently on a local authority housing list? Yes No

If Yes

(a) Which LA Housing List(s) _____

(b) Date of entry onto Housing List(s) month year

month year

(c) When did you last make contact? month year

month year

H09 Have you ever lived in local authority accommodation? *(Tick as Appropriate)*

Yes No Don't know

If Yes

(a) Have you ever been asked to leave your housing due to anti-social behaviour?

Yes No

If Yes

(1) By whom?

(2) What type of anti-social behaviour?

Section 3 – Alcohol and Drug Use

This section will deal with the use of alcohol and drugs. Mention to the client that any information provided will be treated with confidence and only used for research purposes. Stress also that if the respondent does not want to answer a question, he/she is not compelled to but that any information provided will be very helpful.

Alcohol Use

AD01 Alcohol Use

Show/Read Cards

	Never	Monthly or less	2-4/mt	2-3/wk	4+/wk
1. How often would you have a drink containing alcohol? (number of days per week)	<input type="checkbox"/>				

If never consumes alcohol (Question 1 above) go to ADO5 page 11

	1 or 2	3 or 4	5 or 6	7 to 9	10 +
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	<input type="checkbox"/>				

	Never	Monthly or less	2-4/mt	2-3/wk	4+/wk
3. How often do you have more than 6 drinks on one occasion?	<input type="checkbox"/>				
4. How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/>				
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/>				
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="checkbox"/>				
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/>				
8. How often during the last year have you been unable to remember what happened the night before because of drinking?	<input type="checkbox"/>				

	No	Yes, but not in the last year	Yes, during the last year
9. Have you or someone else been injured as a result of your drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AD02 How old were you when you had your first alcoholic drink? (years)

If staying in emergency accommodation (shelters, hostels, B&Bs) answer questions AD03 and AD04

AD03 Are staff aware of your alcohol use? *(Tick as Appropriate)*
 Yes No Don't know

AD04 Have you ever had any difficulties in accessing accommodation as a result of your alcohol use? *(Tick as Appropriate)*
 Yes No Don't know

If Yes
 What difficulties?

Drug Use

AD05 Have you (ever used/used in the last year/used in the last month) any of the following substances? (Tick as Appropriate)

	Lifetime Use (Ever)	Recent Use (Last Year)	Current Use (Last Month)
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Opiates ¹ (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine Powder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (i.e speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-Depressants (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens ²	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 Methadone, Morphine, DF118 (dihydrocodeine tartrate), Temgesic (buprenorphine), Diconal (dipipanone hydrochloride), Palfium (dextromoramide).

2 LSD, PCP, Magic Mushrooms, Ketamine.

If currently uses none of the above go to Section 4 – Health Status Page 19

AD06 In terms of your current use of drugs [refer to those mentioned above], what is your main route of administration and frequency of use over last four weeks? (Answer as Appropriate)

	Route of Administration ^a	Frequency of Use in last 4 weeks ^b
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Other Opiates ¹ (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Crack	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine Powder	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (i.e. speed)	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Anti-Depressants (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogens ²		
Solvents		
Steroids		
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

a 1. Intravenous; 2. Intramuscular; 3. Skin-Popping; 4. Smoke; 5. Ingest; 6. Sniff; 7. Don't Know

b 1. 20 days or more; 2. 10-19 days; 3. 4-9 days; 4. 1-3 days

1 Methadone, Morphine. DF118 (dihydrocodeine tartrate), Temgesic (buprenorphine), Diconal (dipipanone hydrochloride), Palfium (dextromoramide).

2 LSD, PCP, Magic Mushrooms, Ketamine.

AD07 What was the first drug you ever used?

AD08 What age were you when you first started using this drug? years

AD09 Did you first start using drugs...

Read options

(Tick as Appropriate)

Before Becoming Homeless

After Becoming Homeless

If staying in emergency accommodation (shelters, hostels, B&Bs) answer questions AD10 and AD11

AD10 Are staff aware of your drug use? *(Tick as Appropriate)*

Yes No Don't know

AD11 Have you ever had any difficulties in accessing accommodation as a result of your drug use?

(Tick as Appropriate)

Yes No

If Yes

What difficulties?

AD12

The following questions concern information about your potential involvement with drugs during the last 12 months (i.e. recent or current use).

In the statements “drug abuse” refers to:

1. The use of prescribed drugs or over the counter drugs in excess of the directions;
2. Any non-medical drugs (including cannabis, solvents, tranquillisers, barbiturates, cocaine, stimulants, hallucinogens or opiates).

Please answer every question. If you have difficulty with a statement, then chose the response that is mostly right.

1. Have you used drugs other than those required for medical reasons?	Yes (1) No (0)	<input type="checkbox"/>
2. Do you abuse more than one drug at a time?	Yes (1) No (0)	<input type="checkbox"/>
3. Are you always able to stop using drugs when you want to?	Yes (0) No (1)	<input type="checkbox"/>
4. Have you had “blackouts” or “flashback” as a result of drug use?	Yes (1) No (0)	<input type="checkbox"/>
5. Do you ever feel bad or guilty about your drug use?	Yes (1) No (0)	<input type="checkbox"/>
6. Do those close to you ever complain about your involvement with drugs?	Yes (1) No (0)	<input type="checkbox"/>
7. Have you neglected your family because of your use of drugs?	Yes (1) No (0)	<input type="checkbox"/>
8. Have you engaged in illegal activities in order to obtain drugs?	Yes (1) No (0)	<input type="checkbox"/>
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped using drugs?	Yes (1) No (0)	<input type="checkbox"/>
10. Have you had medical problems as a result of your drug use? (e.g. memory loss, hepatitis, convulsion, bleeding etc.)	Yes (1) No (0)	<input type="checkbox"/>
Total Score		<input type="checkbox"/> <input type="checkbox"/>

AD13

Show/Read Cards

	Never or Almost Never	Sometimes	Often	Always or Nearly Always
1. Did you ever think your use of (drugs) was out of control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did the prospect of missing a smoke/snort/‘turn on’ make you very anxious or worried?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AD15 Have you ever injected drugs? *(Tick as Appropriate)*

Yes No

If never injected go to [Section 4 – Health Status – page 19](#)

If ever injected ask the following:

AD16 What age were you when you first injected?

years

AD17 What was the first drug you injected?

AD18 Have you injected drugs in the last 4 weeks? *(Tick as Appropriate)*

Yes No

If injected in the last four weeks ask questions [AD19 – 26](#)

If client has not injected in the last 4 weeks go to [Section 4 – Health Status – page 19](#)

AD19 Do you usually inject yourself?

Read Options

(Tick One)

Always

Sometimes

Never

AD20 What is your most common injecting site?

AD21 Do you have difficulty in finding an injecting site?**Read Options***(Tick One)*

- Always
- Sometimes
- Never

AD22 In what place do you usually inject?**Don't Read Options***(Tick One)*

- Park
- Street
- Place of Residence
- Home of Friends/Family
- Public Toilet
- Other (please specify) _____

AD23 In the last four weeks have you done any of the following?**Read Options***(Multiple Responses Allowed)*

- Shared spoons/filters
- Given anyone your injecting equipment
- Used others' injecting equipment

AD24 In the last four weeks how many times, have you used a needle after someone else has already used it?**Don't Read Options***(Tick One)*

- Never
- One time
- Two Times
- 3-5 times
- 6-10 times
- More than 10 times
- Don't Know/Unsure
- Refused

AD25 Do you usually inject...?

Read Options

(Tick One)

Alone

With Others

With Partner

AD26 Has your injecting behaviour changed since becoming homeless?

Section 4 – Health Status

HS01 Do you currently suffer from any of the following complaints? *(Tick if Yes)*

1. Physical

- Headache
- Problems with bones and joints
- Eye and Ear Complaints
- Foot Problems
- Skin Problems
- Dental Problems

2. Chronic Physical Health

- Asthma
- Bronchitis/Emphysema
- Peptic Ulcer Disease
- High Blood Pressure
- Heart Disease
- Rheumatic Disease
- Epilepsy
- Gastro-Intestinal Tract
- Urinary Tract
- Diabetes
- Tuberculosis
- Other _____

HS02 Have you ever received a Hepatitis B vaccination? *(Tick as Appropriate)*

Yes No

HS03 Have you ever had a Hepatitis B, C test? (Tick if Yes)

Hep. B

Hep. C

Length of Time Since Last Test? (Hep. B) Years Months

Length of Time Since Last Test? (Hep. C) Years Months

HS04 What is your current Hepatitis (B, C) Status? (Tick as Appropriate)

Don't Read Options

	Hep B	Hep C
Positive	<input type="checkbox"/>	<input type="checkbox"/>
Negative	<input type="checkbox"/>	<input type="checkbox"/>
Don't Know	<input type="checkbox"/>	<input type="checkbox"/>

If Positive

(a) Are you currently receiving any treatment? (Tick as Appropriate)

Yes No

(b) If yes, what type of treatment?

HS05 Have you ever had a HIV test? (Tick as Appropriate)

Yes No

Length of Time Since Last Test? Years Months

HS06 Are you aware of your current HIV status? (Tick as Appropriate)

Yes No Don't Know

Can volunteer result– otherwise don't question their status.

HS07 Do you have a current medical card?**Don't Read Options***(Tick One)*Yes, current Yes, near expiry date How long ago did you last renew/receive card? years monthsYes, out of date How long ago did you last renew/receive card? years monthsNo, can't get one

Why? _____

No, don't need one Process of Applying **HS08 Only if injects****HS08 In the last three months have you experienced any of the following injecting related complaints...?****Read Options***(Multiple Responses Allowed)*Abscesses/Infections Dirty Hit (made feel sick) Accidental Overdose Scarring/Bruising Difficulty Injecting **Mental/Psychiatric Health****HS09 Have you ever had any concerns about your mental/psychiatric health? (Tick as Appropriate)**Yes No **If Yes**(a) What concerns? _____
_____(b) Have you ever sought help for these concerns? *(Tick as Appropriate)*Yes No

In terms of mental health, have you ever...?

Read Options

(Multiple Responses Allowed)

- Undergone a Psychiatric Assessment
- Been Admitted to a Psychiatric Hospital
- Been Diagnosed with a Psychiatric Illness

If Diagnosed

(a) Are you currently receiving any treatment for your psychiatric illness?

Yes No

If Receiving Treatment

(b) What type of treatment?

Read Options

(Multiple Responses)

- Counselling
- Prescribed Medication
- Community Psychiatric Services
- Other

Section 5 – Income

IN01 Which of the following sources of income do you have?

Read Options

(Multiple Responses Allowed)

- | | |
|---|--------------------------|
| Regular Employment | <input type="checkbox"/> |
| Odd Jobs/Occasional Labour
(specify) | <input type="checkbox"/> |
| Government Benefits/ Payments | <input type="checkbox"/> |
| Relatives/Partner/Friends | <input type="checkbox"/> |
| Begging | <input type="checkbox"/> |
| Criminal Activities | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> |

IN02 Where do you get most of your money from?

Refer to Options Selected

(Main Response)

- | | |
|------------------------------|--------------------------|
| Regular Employment | <input type="checkbox"/> |
| Odd Jobs/Occasional Labour | <input type="checkbox"/> |
| Government Benefits/Payments | <input type="checkbox"/> |
| Relatives/Partner/Friends | <input type="checkbox"/> |
| Begging | <input type="checkbox"/> |
| Criminal Activities | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> |

Section 6 – Contact with Services

CS01 Have you been in contact with any of the following homeless services within the last month?

Read and/or Show Card

(Multiple Responses)

- Emergency Accommodation (Hostels, B&B)
- Street Outreach Services
- Drop-in Centres
- Homeless Advice Centres
- Food Services
- Settlement
- Transitional Housing
- Day Programmes
- Multi-Disciplinary Team
- Homeless Persons Unit (James St., Wellington Quay)
- Other (specify) _____

CS02 In your opinion, what attracts you to particular homeless services?

CS03 Have you ever experienced any difficulties in accessing homeless services?

Yes No

If Yes

What difficulties?

CS04 Have you ever been refused access to homeless services?

Yes No

If Yes

For what reasons?

CS05 How do you think homeless services could be improved?

CS06 Has other people's alcohol use ever affected you accessing accommodation?

Yes No

If Yes

In what way?

CS07 Has other people's drug use ever affected you accessing accommodation?

Yes No

If Yes

In what way?

QUESTIONS CS08-CS12 ONLY APPLICABLE IF SCORED 3 OR HIGHER ON PAGE 12
IF SCORED 0 TO 2 PLEASE GO TO CS13 PAGE 20

CS08 Have you been in contact with any of the following drug services within the last month?

Read and/or Show Card

(Multiple Responses Allowed)

- Syringe Exchange
- Drop-in Centres
- Methadone Maintenance
- In-patient Detox
- Out-patient Detox
- Counselling
- Outreach
- Community Addiction Teams
- Residential Drug-Free Prog.
- Narcotics Anonymous
- Other (*specify*) _____

CS09 Have you ever experienced any difficulties in accessing drugs services in general?

Yes No

If Yes

What difficulties?

CS10 Have you ever experienced any of difficulties in accessing methadone treatment programmes?

Yes No

If Yes

What difficulties?

CS11 How do you think drug services could be improved upon to cater for the homeless?

CS12 What kind of drug services would you like to see exist?

CS13 Have you had contact with any of the following services/personnel within the last month?

Read Options

(Multiple Responses Allowed)

- GP Services
- General Hospital Clinics
- Accident and Emergency Services
- Psychiatric Clinic
- Community Psychiatric Nurse
- Multi-Disciplinary Team
- Community Welfare Officers (H.P.U)
- Social Worker
- Local Authority Office
- Gardaí

Section 7 – Assessment of Current Needs

CS14 What would you regard as your main service needs at the moment?

Read Options

(Multiple Responses Allowed)

Stable Accommodation

Emergency Accommodation

Counselling/Treatment – Drug or Alcohol

Counselling/Treatment – Mental Health

Employment/Training

Health Care

Legal Services

Support Services/Social Support

Other *(please specify)*

CS15 In your opinion what do you think is preventing you from accessing these services?

Repeat services provided by respondent

Section 8 – Background Information

Finally, I would like to ask you a few more questions about yourself:

BI01 What is your highest level of education?

(Tick as Appropriate)

- Primary Education or Less
- Lower Second Level Education
(incl. group/inter/junior cert/GCSEs)
- Upper Second Level Education
(incl. leaving cert/A levels)
- Higher Education (Third Level – Diploma/Degree)
- Other *(please specify)* _____

BI02 What is your current employment status?

(Tick as Appropriate)

- In Part-Time Employment
- In Full-Time Employment
- FÁS/Training Course
- Unemployed*
- Unavailable for Work/Disability Allowance
- Childcare/Childrearing
- Student
- Other *(specify)* _____

*How long have you been unemployed? Years Months

BI03 Have you ever spent any time in prison?

Yes No

BI04 What is your current legal status at the moment?

(Tick if Yes)

- No Legal Trouble
- Contact with Probation/Community Services
- On Bail Awaiting Trial/Sentencing
- Outstanding Warrants
- Outstanding Fines
- Other (specify)

Thank interviewee for participating in the research.

Signatures to Confirm that Payment (15 Euro) was Provided upon Completion of Interview.

Initials of Interviewee Date

Signature of Fieldworker Date

Any additional information fieldworker may think pertinent

(Record any observations, thoughts, impressions or questions arising from interview)

Appendix 2

Qualitative Interview Guide – Service Providers (Drug/Homeless)

Qualitative Interview Guide – Service Providers (Homeless)

Part One - Organisational Details

1. Type of homeless service provider (i.e drop in, food centre, hostel etc.)

2. Range of services provided within the organisation

3. No. of clients per week on average

4. No. of people who work in the organisation

5. No. of people who have direct contact with homeless persons

6. Your role within the organisation

7. Level of contact you would have with homeless persons

Part Two – Profile of Service Users: Characteristics & Circumstances

1. Describe the proportion of your clients who are alcohol users.
2. Describe the proportion of your clients who are users of illicit drugs.
3. What drugs do they use?
4. How do homeless drug users differ from other homeless people who use your service?
5. To what extent does the drug-using status of clients influence service delivery?
6. In your opinion, what is the nature of the relationship between drug use and homelessness?
7. Describe the degree of knowledge and training which exists among the service workers regarding drug use.

Part Three – Responding to Drug Use among the Homeless

1. What would you say are the particular challenges in working with homeless individuals who are drug users?
2. What support/services do you offer to homeless drug users?
3. Does your organisation operate any policies with regards to alcohol/drug use?
4. Describe the policies your organisation has in relation to drug issues.
5. How does your organisation respond to various drug-related issues [Elaborate: drug use on the premises, drug possession/dealing etc]?
6. Describe the range and level of sanctions which you currently employ
7. Under what circumstances would homeless drug users be excluded from your service?
8. What records do you keep of incidents with drug-related issues?
9. Describe any particular problems your organisation has experienced regarding service provision for homeless drug users.
10. Describe any areas of good practice which your organisation currently operates, or has operated in the past, to cater for the needs of homeless drug users.

Part Four – Service Needs of Homeless People

1. What services, if any, are provided locally for homeless drug users?
2. What are the strengths in local service provision for homeless/homeless drug users?
3. What are the weaknesses in local service provision for homeless/homeless drug users?
4. What is the nature of the relationship you would have with drug service providers?
5. In what areas do you think services could be improved to cater for the multiple needs of the homeless?
6. In your opinion, what would you see as the main barriers towards catering for the needs of this client group?
7. Any difficulties in working with other organisations. [Elaboration: professional/organisational barriers, different obligations, longer duration of multi-agency work]?

Qualitative Interview Guide – Service Providers (Drugs)

Part One – Organisational Details

1. Type of drug service provider (i.e needle exchange, methadone programme, residential service etc.)

2. Range of services provided within the organisation

3. No. of clients per week on average

4. No. of people who work in the organisation

5. No. of people who have direct contact with drug users

6. Your role within the organisation

7. Level of contact you would have with drug users

Part Two – Profile of Service Users: Characteristics and Circumstances

1. What proportion of your clients is homeless?
2. How do homeless drug users differ from other drug users in terms of their needs and characteristics?
3. To what extent does the homelessness status of clients influence service delivery to clients?
4. Describe the degree of knowledge and training which exists among the service workers regarding homelessness and related issues?

Part Three – Providing Services to “Out-of-Home” Drug Users

1. How does your organisation respond to the issue of homelessness among clients within everyday service practices?
2. Do you have any services that specifically target homeless drug users?
3. What are the strengths of your service in dealing with homeless people?
4. What are the weaknesses of your service in dealing with homeless people?
5. In your opinion, to what extent does a client’s homeless status impact on their access to, and retention in, drug treatment?

Part Four – Service Needs of “Out-of-Home” Drug Users

1. What is the nature of the relationship you would have with homeless service providers?
2. To what extent do you feel drug services within the locality meet the needs of drug users who are homeless?
3. Are there any particular gaps in service provision which you feel would be beneficial in helping you to meet the needs of homeless drug users?
4. How could drug service provision in general be improved to cater for the needs of the homeless drug users?

