



PERSPECTIVES

on Irish
HOMELESSNESS
past, present and future

**HOME
LESS**
agency

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Perspectives on Irish Homelessness: Past, Present and Future

*Edited by
Dáithí Downey*

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Foreword

Homelessness is among the biggest challenges faced by Irish society. As we move towards the end of the first decade in this new millennium we should take stock of where we are and what we need to do to meet this challenge. Homelessness, however unacceptable in principle, is a lived reality that is still manifest in Irish society. Despite the advances made in Ireland over the last 10 years in terms of economic growth and development and the general success and improvements that came with these positive changes, we find that the challenge of homelessness remains.

It is, however, a challenge that has not gone unheeded or unmet. In Dublin, the Homeless Agency Partnership continues to develop effective partnership working between local authorities, the Health Service Executive and voluntary and community agencies working with people experiencing homelessness. Over the period, this has led to improvements in the quality and range of services provided for homeless persons and has resulted in a reduction in the number of people experiencing homelessness and rough sleeping. The support provided to date by government has also been crucial in bringing about positive change.

Nonetheless, while the challenge of homelessness not only remains, it is also becoming more diverse. Likely future trends in the numbers of persons in Ireland at risk of housing exclusion and homelessness due to the now apparent slowdown in sectors of the Irish economy must be taken into account alongside the now well-established needs of our existing homeless population. The local authority 2008 assessment of housing need and our own census of homeless service users called *Counted In* will soon produce a new benchmark in our knowledge of the extent of the challenge we face.

Yet it is a challenge we are better able to meet than before and with a continued allocation of resources and development of policy, I remain confident of our ability to deliver the Homeless Agency's vision set out in our action plan to 2010, *A Key to the Door*. Our vision is an end to long-term homelessness and the need to sleep rough in Dublin, reduced risk of homelessness and the provision of appropriate care and housing to ensure a person exits homelessness and realises their full potential and rights.

This book is therefore timely and relevant to our vision and I would like to congratulate all involved in bringing it to publication. It is a somewhat unique collection of different ideas, opinions and points of view from a diverse group of individuals each with their own experience and understanding of homelessness today. It deserves to be read closely and I hope it will help inform our thinking and the debate over how we meet the challenge of homelessness in 21st Century Ireland.

**Kathleen Holohan,
Chair of the Board of the Homeless Agency,
Director of Housing, Dún Laoghaire-Rathdown County Council**

Acknowledgements

This publication represents the realisation of an original idea to produce a collection of informative and challenging essays on various aspects of homelessness in Ireland. It succeeds in bringing together a range of different perspectives on Irish homelessness from across a spectrum of academic researchers, independent consultants and analysts, health and housing practitioners as well as homeless service providers. Many people have been involved in the project, including the contributors, anonymous referees and readers and thanks are extended to each person for their co-operation, interest and expertise. A special word of thanks goes to the Homeless Agency staff involved in the project, especially contributors Elaine Butler and Nathan O'Connor for their support and commitment to the project, to Lisa Kelleher for her work preparing the book for publication, to Bernadette McFadden for her sterling work as editorial assistant and lastly to the book's editor, Dáithí Downey, without whom this work would not have been brought forward. Everybody's contribution is highly valued.

**Cathal Morgan
Director
Homeless Agency
July 2008**

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Frank Mills works as a national planning specialist in the Social Inclusion Unit of the Health Service Executive. He has a Masters degree in public administration and has lectured and published in the area of social policy. He has also presented papers at a number of international conferences.

Dr Jane Pillinger works as an independent social policy analyst and policy advisor and is based in Dublin. She has been working on housing and homelessness issues, amongst other areas, for over 20 years is the author of the Homeless Agency's strategy for preventing homelessness. More recently she authored a research report published by Focus Ireland in 2007 on homeless pathways. Jane works with NGOs, government departments, trade unions and employers on a range of social policy issues, as well as with European and international organisations.

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Dr Eoin O'Sullivan works as a Lecturer in the School of Social Work and Social Policy, Trinity College Dublin. He is a member of the Private Residential Tenancies Board and of the European Observatory on Homelessness. His recent collaborative publications include *Lives in Crisis: Homeless Young People in Dublin* (2007); *Crime, Punishment and the Search for Order in Ireland* (2004); *Crime Control in Ireland: The Politics of Intolerance* (2001) and *Suffer the Little Children: The Inside Story of Ireland's Industrial Schools* (2001).

INTRODUCTION

DÁITHÍ DOWNEY

This book is the first attempt by the Homeless Agency to collate a range of disparate and alternative voices on the subject of homelessness in Ireland. Its purpose is to try and tell us something more about the phenomenon of homelessness and how it is experienced and understood today, how that has changed over time and what it may become in the near future. It does not pretend to be the last word on the matter, nor indeed is it the first word.

Homelessness is a regular feature of interest to the mass media in Ireland, offering as it does images and stories that present a striking contrast to the recent experience of mainstream Irish society. This contrast is thrown into even sharper relief than heretofore by the very obvious public manifestations of wealth in our *arriviste* and *nouveau riche* consumer society. Public opinion on homelessness has certainly changed over time but is, more often than not, a combination of empathy with the plight of an individual or household 'down on their luck', tempered by a harder, less tolerant perspective perhaps reflective of an understanding of homelessness as some kind of pathology. This point of view considers homelessness as a state of being attributable to the individual experiencing it and seeks a solution to the issue on the basis of the individual's ability or willingness to 'opt in' and 'get on'.

Arguably both perspectives rely on overly simplified understandings of what is a complex social, economic and human phenomenon. What causes homelessness and what is attributable to the experience of homelessness, of 'being' homeless, are two related but also separate things. In trying to understand homelessness we cannot ignore or discount the importance of structural economic issues such as employment and wage rates, or the transmission of intergenerational poverty through families and sometimes whole communities, or the operation of the housing market as well as the quality of public service provision in areas such as health, welfare and education. The direction and impact of social policy and government decision-making is also important.

We are beginning to explore and understand the complexity of homelessness in a more meaningful and useful way, and notably many contributions to this book utilise the concept of a 'pathway' into, through and out of homelessness. This is a result of the increased purchase of the pathways approach to investigating homelessness among the Irish research community. Its influence is demonstrable in the way this variant on the life course and longitudinal approach to research, is helping to improve policy decision makers' understanding of what works in practice to ensure the development and delivery of an appropriate service response to the needs of people experiencing homelessness. This is still a relatively new departure in the approach to homeless policy and practice. Nonetheless, its emphasis on developing an understanding of homelessness that embraces the dynamics of movement into and out of different situations over a person's lifetime is echoed across the national social policy system where the aim is to support and facilitate the development of each person, enabling them to reach their full potential. Attempts are now underway to refine overall Irish welfare state activity in public service provision, income supports and activist or innovative measures that are focussed in ways that become integrated and developmental for individuals, families, communities and the economy¹.

To begin with however, in the opening chapter of this book, Brian Harvey brings us back to a time when people who experienced homelessness in Ireland simply did not feature in the policy narrative of the Irish state. His telling of the story of where Irish society started from and how we got to where we are today in relation to homelessness is enlivened with insights drawn from Brian's first-hand experience of making the issue visible to both the general public and government through his participation in what we now refer to as the new social movements of the 1960s. Brian characterises the 1988 Housing Act as the cornerstone legislation on homelessness in Ireland but is forthright in attributing its passage into law to the importance of an assertive voluntary and community sector. He is critical of subsequent policy decision-making and argues there is an insufficient understanding of implementation theory and practice as well as considerable resistance to change among both voluntary and statutory sectors involved in homeless service provision. Brian's argument that more than 20 years after the passage of key legislation, there is limited evidence of a significant shift in the behaviour, operations and attitudes toward the homeless in Ireland is a challenge to us all.

Evidence-based policy decision-making is the new frontier in delivering social change in Ireland. In order to command the argument for scarce resources among a plethora of competing needs and demands made on government and other decision-makers, we are increasingly required to evidence not only the extent of homelessness but also what works to end and prevent homelessness. The evidence debate on homelessness is

¹ For further reading see National Economic and Social Council (2005) *The Developmental Welfare State*, Dublin, NESCC.

becoming increasingly contested and a number of authors refer to the challenges of how we might respond to the new public management agenda being established in policy decision-making.

In chapter two, Eoin O'Sullivan critically reviews research undertaken on homelessness in Ireland since the 1970s and queries the evidence base this research has generated. Eoin identifies 128 different reports, books, book chapters and journal articles on Irish homelessness and delivers an authoritative analysis of their focus, content and methodology. He shows how the focus of much Irish research over the period can be characterised as concerned with enumerating the homeless, identifying their needs and proposing remedies to alleviate their distress. His conclusion is that quantitative cross-sectional methodologies dominate Irish research output and that this tendency is counter to a broad, international consensus that such approaches can distort our understanding of homelessness and hence policy responses. Indeed, Eoin suggests that policy options in relation to Irish homelessness may not necessarily be influenced by research at all. However, where this is more likely to be the case, Irish researchers will need to expand their methodologies to include a greater emphasis on longitudinal approaches that track the dynamic nature of homelessness. Eoin also cautions researchers to avoid recommendations to policy makers based not on the research evidence, but more so on the ideological perspective of the body commissioning the research.

Later, in chapter six, Nathan O'Connor takes up this challenge and sets out to try to deliver a way to answer the question of how many people are homeless. In a thought-provoking manner, Nathan demonstrates how, over time, different measurements of the extent of homelessness have been based on differing approaches to the definition of homelessness. He illustrates how this tends to lead to a heated contest about the correct number of homeless people at any one time. His proposed solution is elegant in its simplicity. Adopt a more scientific approach to measuring homelessness that allows observers to see exactly what is being measured and how the findings were generated and arrived at. If this were to occur, argues Nathan, it may allow us to shed more light on the complexity of homelessness and avoid the situation where misleading and unhelpful demands for a simple answer are sought to what is a complex question.

Certainly many people who have experienced homelessness in Ireland have found and secured a pathway through and away from their experience of homelessness. This exit from homelessness relies on a combination of their own capacity and resilience with their ability to take up appropriate service responses to their needs that are available upon demand. Critically, their ability to access affordable and appropriate housing and accommodation is pivotal when realising this exit. In such circumstances, it seems people can get on with getting through, and out, of homelessness.

Yet we also know that episodic experiences of homelessness can be a precursor to repeat experiences of homelessness and that individual resilience and capacity to maintain a pathway out of homelessness can only truly be maintained when the services an individual requires are in place, are properly resourced and available and operate to the quality standard required to ensure real change and positive, sought-after outcomes. Quality and access are important issues here. Just as access to quality housing options can support an exit from homelessness, poor housing quality combined with poor housing options can deny it. Bad housing wrecks lives, lowers resilience and erodes a person's capacity to exit homeless and exclusion.

These themes are taken up by a number of this book's authors. In chapter three, John-Mark McCafferty offers us a lens on the lived experience of homelessness in Ireland and by doing so reminds us how homelessness is about more than just scientific measurement, policy buzzwords and budgets. John-Mark argues that we forget to put the person in the middle of policy or service provision at our peril. He reminds us how the portrayal of a typical homeless person is achieved through a combination of established and stereotypical narratives that combine to separate out the homeless person as an 'other' in Irish society, an outsider with no stake in society and who is therefore perceived as a possible threat. John-Mark offers the reader an experience of the 'other' that he has found for himself and raises fundamental questions about identity, relationships and justice. Nothing, it seems, is straightforward in the experience of homelessness among service providers and users and John-Mark argues how a further exploration and understanding of the organisational cultures of service providers is essential to the ultimate aim of eliminating homelessness in Ireland.

Homelessness is regularly an outsider's story told from afar and viewed from a distance. In contrast, two of our authors bring us up close and personal with the reality of homelessness by adopting what was previously introduced as the pathways approach to researching the issues involved. In chapter seven, Jane Pillinger introduces us to this life course approach to investigating pathways into, through and out of homelessness and recounts the findings of her research based on in-depth interviews with adult homeless service users in Dublin. She reiterates the need for both policy makers and service providers to address the causes of homelessness and to identify and tackle risks that trigger homelessness. Jane delivers a compelling argument for the adoption of the pathways approach into homeless policy formulation and stresses the key finding from her research that the most important factor contributing to a pathway out of homelessness is the provision of adequate, secure and affordable housing.

Paula Mayock brings young people's pathways through homelessness to our attention in chapter eight. In a powerful analysis that utilises verbatim first-hand quotations from homeless young people, Paula illustrates how a young

person's pathway through homelessness is often characterised by experiences of criminal behaviour but also by victimisation. She theorises how homeless young people's daily experience of negotiating their way through hostile environments and marginal spaces can feed back into patterns of risk-taking behaviour. Sometimes such behaviour becomes established as part of a young person's coping mechanisms and may cause them to become further enmeshed in a life of homeless exclusion and disaffiliation from society. Policy makers and service providers, she argues, must take this reality into account.

A place to call home is the clear and unyielding demand of homeless households and in chapter nine, David Burke sets about unravelling the complexities of the Irish housing system to support his argument of why this demand is at times impossible to meet. His perspective may be characterised as heavily laden with a *realpolitik* that asks us to recognise the dichotomy in the Irish housing system between the dominant housing tenure occupied by the majority of the Irish population, namely owner occupation, and the more residualised elements of the rental tenures. In considering the results of this dichotomy, David argues that within the welfare-based housing system of local authority and housing association social rental housing as well as privately rented housing with rent supplement, homelessness and housing interact in a way that restricts the choice of homeless individuals and families to insecure and substandard accommodation. He posits the question whether Ireland's inability to provide access to quality housing and thereby to homes is indicative of our society's willingness and capacity (or lack thereof) to seriously address homelessness.

Sharon Cosgrove enumerates the links between domestic violence and homelessness in Ireland in chapter 10. She highlights the implications of not recognising domestic violence as a cause of homelessness and argues how a lack of policy coherence and awareness regarding domestic violence as a pathway into homelessness has hindered progress, resulting, for example, in a 12 year delay in opening a domestic violence refuge in Dublin. The Irish government's much anticipated revised national strategy on homelessness is however suggestive that a coordinated 'whole of government' approach to addressing homelessness and its causes, including domestic violence, is attainable. Sharon welcomes the recent establishment of a national office for domestic violence (called Cosc) as a potentially significant step in doing so.

Three consecutive chapters turn our attention to the issues of care and health for and among people experiencing homelessness. In chapter 11, Elaine Butler offers us evidence of how a care and case management approach to the delivery of services to homeless persons will work. It will help ensure that complex needs are identified, assessed and responded to using care plans that draw in the resources and multidisciplinary skills required to deliver care. It will also work to ensure the overall impact is likely to be both improved value for money and greater effectiveness in service provision. By telling the story of how an emphasis on the development and implementation of care and case management has come to be strategically important for the homeless sector in Dublin, Elaine sets out to challenge policy makers to question the risks of getting service delivery wrong, versus the rewards of getting it right. While avoiding presenting a simplified win-win scenario as the immediate or even medium-term outcome, she argues that the reallocation of resources and changes in the delivery of service responses will present managerial and administrative hurdles, yet overcoming these is essential and we are duty bound to do so to prevent homeless people falling further through the cracks.

In chapter 12 Frank Mills, Brian McLaugh and Austin O'Carroll describe and discuss the development of primary health care services for homeless people in Dublin. The authors outline models of service provision for the homeless population, present a rationale for a service that 'catches' otherwise unseen patients, and explain how the ideal scenario is one in which homeless patients are not treated apart from the mainstream healthcare delivery system but are equally able to access mainstream provision. Mills, McLaugh and O'Carroll argue that the Health Service Executive's national transformation process offers the opportunity for homeless clients to become a part of mainstream health services. The analogy of being both entitled and able to pass through the front door rather than having to go around the side or to the back door is a simple yet appropriate way to characterise their aspirations for homeless persons seeking access to all forms of health service provision.

By telling the story of John, a 32-year-old seriously ill homeless man in Cork, Don Coffey and Joe Finnerty illustrate in chapter 13 the importance of tailored, site-specific health service provision for homeless persons. They detail how the Cork City Adult Multidisciplinary Team works as a conduit between specialised health services and the generic primary care service and thereby enables homeless people to access mainstream health services. Notwithstanding its obvious success, Coffey and Finnerty raise questions over the sustainability of this model of service without proper funding and recognition of its innovative value. They argue that outcome measurement using performance indicators is fraught with difficulty for the homeless population and may be inappropriate overall as a determining factor in demonstrating cost effectiveness and providing value for money. Alternatively, measures of well being that demonstrate the benefits of a preventative approach to health care and provision in terms of reduced morbidity and illness are arguably more useful measures of success or failure.

Lastly, we return to homeless policy matters and to a focus on recent trends and developments. In chapter five Isobel Anderson, Evelyn Dyb and Joe Finnerty examine recent developments in Irish homeless policy and housing provision within a comparative context. They situate their analysis in the broader context of comparative

approaches to theorising European welfare states before focusing in on Scotland and Norway as comparators for the Irish case. They compare the three countries in relation to three key issues. Firstly, issues relating to the definition and measurement of homelessness. Secondly, in relation to the profile of homeless people and thirdly in relation to changes in homeless policy, as well as housing options available for homeless people. The authors argue that despite differing welfare regimes and policy-making structures, certain aspects of homeless policy, including tendencies towards neo-liberalism, are increasingly common between Ireland, Norway and Scotland.

At the time of writing, publication of the revised national adult homeless policy and strategy to 2013 – provisionally entitled *The Way Home* – is keenly awaited. Although imminent, its arrival is considered by some contributors as somewhat overdue given the lengthy lead-in time for its development since the completion of the Fitzpatrick Review of national adult homeless policy and its submission to government in 2006. Yet this hiatus in the publication of policy has provided the space and time for a newly constituted National Homelessness Consultative Committee (NHCC) to become established and participative in deliberations over policy content and direction. The NHCC was established as a direct result of the Fitzpatrick Review and has arguably helped to strengthen the national homeless policy making process. Importantly, the NHCC has ensured the experience of the Homeless Agency partnership's ongoing work to implement *A Key to the Door*, our action plan to 2010, is being taken into account in the development of the new homeless policy framework. Indeed, the Homeless Agency vision, set out in early 2007 with the launch of *A Key to the Door*, to eliminate long-term homelessness and the need to sleep rough in Dublin is now echoed as a key aim for revised national policy.

Consequently, in chapter four, Andrew Brownlee (one of the lead consultants who conducted the Fitzpatrick evaluation and review of policy) offers a cautious but optimistic view of the newly unfolding homeless policy landscape. Based on insights drawn from his experience of conducting the review, Andrew tells the story of how government quickly accepted the broad thrust as well as detail of the recommendations made. Cognisant of the time since then to now in issuing a new policy framework and strategy, Andrew identifies as key explanatory factors firstly what he considers as resistance between NGO and voluntary sector homeless service providers to certain recommendations made in 2006 requiring a reallocation of resources. Secondly, he identifies a subsequent period of restructuring within stakeholder organisations as having an impact on how implementation of the review's recommendations are negotiated and agreed. It appears some of the lessons from a previous period are still very relevant today as both Brownlee and Harvey hold critical views on policy implementation in common, despite referring to different periods of policy making and delivery.

Events, it seems, have overtaken certain opportunities surrounding an otherwise well-established policy consensus among social partners and government on how to meet the ambitious but laudable aim of eliminating homelessness from Irish society. Certainly the opinion of contributors to this book confirm it is debatable whether the hiatus in policy is now an impasse that has arisen as a result of wider changes in the economic environment and political landscape since 2006. Nonetheless, while undoubtedly suffering from a period of drift, it is highly significant that Irish homeless policy remains committed to the elimination of long-term homeless and an end to rough sleeping. These commitments are also established in wider policy frameworks such as the new housing policy *Delivering Homes, Sustaining Communities* (2007) and the latest social partnership agreement *Towards 2016*. Alongside these are commitments in the National Development Plan (2007-2013) *Transforming Ireland – A Better Quality of Life for All*, to invest €17bn for social housing provision and renewal to provide 60,000 new units of housing over the period to 2013. Therefore the opportunity to ensure homeless policy responses deliver a pathway away from crisis homelessness and emergency accommodation and into independent living, fuller participation in society and the realisation of a person's human rights is perhaps greater than ever before. Yet questions remain about how this will be done and when.

When the authors of the respective chapters in this book gathered for a meeting to discuss their contributions and to exchange different points of view, there was a lively debate that produced noticeable consensus on the need to ensure we create and support champions for the homeless at all possible levels. Champions are needed for the evidence-based policy interventions that build pathways out of homelessness. Champions are required to undertake research that gathers evidence and helps to produce the burden of proof required to demonstrate how positive, sought-after change is achievable. Champions are necessary to deliver practices that drive service standards upwards and deliver access to quality services that respond to meet the needs of people experiencing homelessness in a timely fashion. Preventative champions are needed who will work to reduce the risk of homelessness and prevent repeat homelessness. Lastly, and perhaps the most strongly felt and held view of all, was the need for public champions to vociferously demand an end to homelessness in Ireland. This can be done on the basis of the simple and straightforward understanding that homelessness is not a permanent state for the individual or household, nor should it be considered so or accepted as such. Public champions that will use their voice to maintain their demand to end homelessness are considered crucial by this book's contributors because, as this book tells us, failure to act on homelessness is not just a risk for the individual or household, it is a risk to all our futures.

Critical perspectives on Irish homelessness

Chapter 1:

Homelessness, the 1988 Housing Act, state policy and civil society.

Brian Harvey

Chapter 2:

Researching homelessness in Ireland: explanations, themes and approaches

Eoin O'Sullivan

Chapter 3:

Homeless policies and services: making room for the person

John-Mark McCafferty

CHAPTER 1

HOMELESSNESS, THE 1988 HOUSING ACT, STATE POLICY AND CIVIL SOCIETY

BRIAN HARVEY

Government spending on homelessness this year will be €86m.¹ There is a dedicated Homeless Agency for the greater Dublin area. There is a perennial debate on the plight of the homeless in the Oireachtas every Christmas in which opposition members vie with each other, in righteous indignation, to denounce government performance. Action on homelessness features as a strand of government anti-poverty strategies. A minister of state has defined responsibility for the issue. There is an interdepartmental working group, a national advisory committee and a national strategy. There is even the suggestion that a substantial industry has grown up around homelessness, a definable sub-set of what a former Minister for Finance once disparagingly called 'the poverty industry'.²

It is hard to believe that it was not always so. Although homeless people, or vagrants as they were then called, featured in the Victorian narrative of social policy, especially after the uprooting of the great famine, they virtually disappeared from the admittedly bare social policy narrative of the new Irish Free State. Only occasionally did the persistence of homelessness enter the public debate, once bubbling up during the passage through the Oireachtas of the Health Bill in 1953. So far as is known, there was only one parliamentary question on homelessness in the entire 1970s.

Although by 1980 the homeless had vanished from the public political discourse, the phenomenon of homelessness had of course far from disappeared. Homeless people were sheltered principally by the Society of St Vincent de Paul, which operated about 11 night shelters in the main urban centres of the state and religious orders on an ad hoc basis. The fact that these organisations chose to operate quietly, with little publicity, contributed to the invisibility of their charges. And of course Ireland exported many of its poor, including its homeless, to Britain.

The defining moment of change came in February 1969 with the visit to Ireland of a London probation officer who had been puzzled as to why so many homeless people in London were Irish. Anton Wallich Clifford established the first new service for homeless people in Ireland for many years, the Simon Community.³ Unlike its well-established contemporaries, the Simon Community believed in making the problem of homelessness visible and in confronting government with its responsibilities. With the slogan 'caring and campaigning', Simon was one of the new social movements of the 1960s that attracted angry young men and women interested in what even the conservative opposition party of the time invoked as 'the just society'.⁴

Making a connection between homelessness and the actions or inactions of government was, in the 1970s, a challenging proposition. It is often said that the most difficult aspect of any political campaign is to get the issue on the political agenda in the first place.⁵ This was no less true of the homeless issue. Indeed, when it eventually reached the floor of the Oireachtas there was a general sense of puzzlement among senators: Surely this is a private matter for charities, like the Society of St Vincent de Paul? Why are you troubling us with this issue at all?

But that is to get ahead of the story. In confronting the authorities with their responsibilities toward the homeless, the Simon Community quickly met a state whose unwritten social policy had little place for those

1 Dail Eireann, Debates, 5th March 2008, 473.

2 Peter McVerry SJ & Eoin Carroll: Homes not hostels - rethinking homeless policy. Working Notes, §56, November 2007.

3 Ursula Coleman: It's Simon - the story of the Dublin Simon Community. Glendale Press, Dublin, 1990.

4 Fine Gael: Winning through to a just society. Dublin, 1966.

5 Working for change, 3rd edition. Combat Poverty Agency, 2008.

without a home. Simon was able to document how homeless people who applied for local authority housing, which was then relatively plentiful, were referred to health boards for assistance. Health boards, with equal convenience and conviction, referred them back to the local authorities.⁶ Indeed, it was the practice of state institutions to discharge homeless people into the care of voluntary agencies, with a note from the social worker to this effect. The situation reflected a somewhat extreme Irish interpretation of the contours of the public and private within European social policy of the period. Worse, though, it was a social policy in which the state had been reducing its responsibilities to the homeless. Although the old county homes had sheltered homeless people since the famine, in the 1960s it was decided that they should now only care for older people. Homeless people were let out of the doors, with nowhere to go and no alternate provision made for them.⁷

Homeless Persons Bill, 1983

This background set the scene for one of the classic confrontations between social activists and the state. The Simon Community formed the view that the state's disavowal of responsibility for the homeless could only be broken by legislation that identified the responsibilities of local housing authorities and health boards. A contemporaneous example of such an approach was available from neighbouring Britain, where the Liberal party had, during the period of the Liberal-Labour pact, prevailed on a reluctant government and local authority establishment to pass the Homeless Persons Act, 1977. This legislation, although much hedged about with qualifications, was a landmark development insofar as it set down a justiciable duty on local authorities to house certain categories of homeless people. Because of the common legal traditions of England and Ireland, the enunciation of such a principle there had an obvious appeal to those interested in the welfare of the homeless in Ireland. The Simon Community supported a candidate for the National University of Ireland panel in the three Oireachtas elections of 1981-3, Brendan Ryan, associated with Cork Simon Community. He pledged to introduce a Homeless Persons Bill. This was the first of three in our story. The Bill was duly introduced in November 1983 as a private member's Bill, with three functions, to:

1. *Define a homeless person in law;*
2. *State that the local authority had a responsibility toward him or her;*
3. *Place an obligation on the local authority to provide suitable accommodation.*

Each of these functions was important in its own right. The first defined a homeless person as someone who had no right to accommodation, either by rental or by ownership and who was dependent on night shelters or similar institutions because of no other place to go. This new definition of homelessness replaced earlier historic definitions, both the archaic (and indeed offensive) term of 'vagrant' and the more sanitised one of 'no fixed abode'. Second, the allocation of responsibility to the local housing authority was important, because it defined homelessness as a problem of lack of housing, breaking the paradigm of homelessness as a personal problem of dysfunction to be addressed by the mental health services. Third, the placing of an obligation arose from Simon's own bitter experience of local authorities turning away homeless people, Simon taking the view that local authorities would only ever house homeless people if compelled, however reluctantly, to do so.

Table 1: The 1980s Homeless bills

<i>Homeless Persons Bill, 1983 (private member's Bill introduced by Senator Brendan Ryan)</i>
<i>Housing (Miscellaneous Provisions) Bill, 1985 (FitzGerald government, 1982-7)</i>
<i>Housing Bill, 1988, now the Housing Act, 1988 (Haughey government, 1987-9)</i>

The 1983 Homeless Persons Bill generated strong reactions. The concept of a 'right' to housing was anathema to an Irish constitution and administrative practice where social rights had not been a prominent characteristic. Echoing the debate on the rights of people with disabilities a generation later, there was a fear by the financial and legal side of government that a right to housing, even only for homeless people, would open up a vista of court actions and unbearable, crippling financial burdens on the state. The Department of the Environment and

⁶ Simon: The case for a homeless persons Act. Dublin, 1983 (1st edition).

⁷ Vincent Doherty: Closing down the county homes. Dublin, Simon Community, 1984.

the local authorities objected on the basis that the legislation would upset the basis on which local authority homes had been allocated to date. This was a correct perception, for the Bill was about including in that allocation a category that had hitherto been excluded. These objections were compounded, in some local authorities, by a visceral reaction against homeless people.⁸ At the time, homeless people were often stigmatised with a language that would not be tolerated in the gentler social climate of the 21st Century.

The original decision of the Fine Gael and Labour government had been to vote down the Bill after a cursory three-hour debate.⁹ When these intentions became known, such was the level of protest by voluntary and community organisations that the government withdrew its motion to decline to give the Bill a reading, while pledging to introduce its own legislation. These events took place over a climactic 48 hour period in November 1983.¹⁰

Housing (Miscellaneous Provisions) Bill, 1985 and Housing Act, 1988

The government eventually responded with its own Housing (Miscellaneous Provisions) Bill, 1985, introduced by the Minister for the Environment. This was somewhat longer than the Simon Bill and included some other functions. The government Bill included the three primary functions of the Simon Bill, but responded to concerns on the local authority part by introducing a number of qualifying clauses, some borrowed from the 1977 British legislation and subsequent case law. For examples, homeless people had to be capable of 'independent living', a return to the popular image of homeless people as being dysfunctional, unstable and incapable.

The Bill made slow progress and was not helped by the troubles that increasingly engulfed the Fine Gael-Labour government of 1982-7. Simon forced the issue to a head a year later, staging a two-day sleep-out outside Leinster House, which successfully saw the Bill approved on second stage. There were suspicions on the voluntary and community sector side that government intention had been, through delay, to test the patience and perseverance of the social activists outside the gates. The campaigners, though, had meantime secured commitments from the opposition party, Fianna Fail, to progress the Bill both in opposition and if returned to government. Fianna Fail withdrew its speakers from the second stage so as to 'collapse' the Bill and ensure its speedy passage (late 1986). In the event, it was the government itself that collapsed shortly thereafter, Fianna Fail coming to power in a minority government led by Charles Haughey.

The new Fianna Fail government was true to its commitment to address the issue of homelessness through legislation, but there was a critical difference in the new, shorter Bill that replaced the Housing (Miscellaneous Provisions) Bill, 1985. The new Housing Bill did not include an obligation on the local authorities: instead, the local authorities would have 'responsibilities which they could discharge in a number of different ways'. There was an emphasis on assessing the numbers homeless and in housing need. A new funding system for shelter providers was introduced (§10). In effect, obligation was replaced by expectation, assessment and enablement. The minister responsible, Padraig Flynn TD, explained informally that the Bill was a compromise: it was less than what the activists wanted, he knew, but he would make sure it was put speedily through and if it didn't lead to results, the activists should come back to him and he would look at it again. The Bill also abolished the offence of being homeless under the old Vagrancy Acts, the government having been encouraged in this direction by a stinging resolution passed by the European Parliament.¹¹

The Housing Bill 1988 was passed with exemplary speed, becoming the Housing Act, 1988 and remains the cornerstone legislation on homelessness more than 20 years later. Labour party amendments to restore the 'right' to housing (or, looked at another way, the obligation on the local authorities) did not attract even Fine Gael support and the activists had to accept that there was not support, in that Dail, for such an obligation. Instead, they focussed on amendments to ensure that the Bill was adequately reported and monitored for its effectiveness in housing homeless people. Such amendments had been stoutly resisted by the department and the minister accepted the guidance he was given.

8 The author recalls that a Dublin city housing manager at the time averred that 'over his dead body' would down-and-outs get housing ahead of 'needy families'.

9 This was the government led by Garret FitzGerald following the general election of November 1982. He was Taoiseach until March 1987. This was the longest lasting government for many years. Although successful in a number of areas (controlling government spending, reducing inflation, maintaining social protection) by 1986 tensions between the two parties in government became more overt and toward the second half of the year it became clear it could not last much longer.

10 Forty eight hours of action. Simon Newsletter, December 1983.

11 This was a resolution introduced by Portuguese Liberal MEP Antonio Lacerda de Queiroz, following the prompting of two Irish members, Mary Banotti MEP and Niall Andrews MEP. The resolution was the first one passed by the European Parliament of its kind and was a comprehensive exposition and denunciation of homelessness in the European Communities. Member states that continued to criminalise the homeless were singled out for especial exhortation.

Implementing the Housing Act

Granted the very mixed record of the local authorities in dealing with the homeless, it was no surprise that the new Housing Act presented many problems of implementation. The Housing Act came in during a period before implementation theory was well understood by government.¹² Not until the National Anti Poverty Strategy 10 years later did an Irish government put significant structures in place to ensure that a policy actually happened. The failed implementation amendments to the Housing Bill were, unfortunately, before their time.

The first evidence of the pattern in which the Housing Act had been implemented came with a report commissioned by the National Campaign for the Homeless a few years later.¹³ This found that in the previous four years, only 157 homeless people had been housed as a direct result of the Act, a small figure compared to the 5,000 people estimated to be homeless at the time. Moreover, the operation of the Act was extremely uneven, patchy and inconsistent, with a substantial number of local authorities paying no attention to key requirements of the Act and the Department of the Environment exercising no effective oversight over its operation. Not until the Homeless Initiative was established in the greater Dublin area (1996) did the government address the problems of implementation in a systematic way, but that was confined to the capital and its environs.

Most public discussion on homelessness in the post-1988 period tended to focus, in a predictably sterile way, on the numbers of people homeless, counting methods and assessment systems. Voluntary and community organisations did not have the resources to invest in the difficult and unglamorous task of monitoring the effective implementation of the Act, nor was government interested to build their capacity to perform such a role. Ensuring the implementation of legislation had none of the romance of the campaign of the previous decade. Although local authorities were expected to establish forums of statutory and voluntary providers to follow the operation of the Act, few did so. This was disappointing but what was surprising was the lack of capacity or preparedness of voluntary and community organisations to press the issue.

Paradoxically, the public profile of the homeless issue rose. End-of-year debates in the Oireachtas on the plight of the homeless became almost routine. Groups working with the homeless received extensive media coverage. Focus Point, later Focus Ireland, rose to prominence not only for its extensive range of services for the homeless, but for its research and policy work. The largest provider of homeless services, the Society of St Vincent de Paul, was transmogrified from a quiet 'insider' organisation to a visible campaigning body for enlightened social change.

Perhaps the most important revolution in homelessness in the 1990s was the least heralded, which was, at last, the investment of significant funding by the government in homeless services. Coinciding with the period of economic growth now known as the 'celtic tiger', government investment in voluntary and community organisations providing social services rose exponentially in the 1990s. Government funding of voluntary and community organisations nationally rose from €271.8m in the early 1990s to over €1.2bn 10 years later.¹⁴ Homeless services benefitted from this trend and the most recent study found 57 organisations at work in the field, running 140 projects and employing about 800 staff. Here, Dublin accounts for the main bulk of these services: 60 projects, with 700 staff, budgeted in the order of €54m.¹⁵ The key word, though, is 'services'. Government, both at central and local level, saw no reason to invest in the advocacy capacity of the voluntary or community sector and did not do so. The reasons for this were complex: the unresolved nature of state-voluntary relationships, the lack of recognition of a civil society space in Ireland, the fear of and inability to handle criticism. When the new Health Service Executive was established, its subsequent formal contracts with voluntary organisations (called Service Level Agreement) effectively prohibited voluntary or community organisations from even trying to 'influence' government policy in any way.

12 Sarah Craig: Implementation - the case of the Eastern Health Board. Master's thesis, University College, Dublin, 1989.

14 For details by government department, see Acheson, Nicholas et al: Two paths, one purpose - voluntary action in Ireland, north and south. University of Ulster and Institute of Public Administration, Dublin, 2005.

15 Simon Brooke: Work worth doing - a review of staffing in homeless services. Dublin, Brunswick Press, 2005.

16 The formal count of homeless people shows 5,581 homeless in 2002, falling to 2,399 in 2005.

Legislation, rights and the public debate

In rejecting the rights argument, with the concomitant obligation on the local authorities, the government argued that local authorities would use the 1988 Act to respond imaginatively to the problems of homeless people. There is evidence that the numbers of homeless people plateaued in the end of the 1990s and have since fallen back, with a continuing downward trend.¹⁶ Indeed, O'Sullivan, in a thoughtful and upbeat assessment of the evolution of homelessness, suggests that Ireland's particular combination of enabling legislation and investment in voluntary services has begun to pay off.¹⁷

He makes a strong case, but there are still some questions. The reduction in homelessness reported in recent years may be principally a feature of Dublin. Not only have resources been concentrated most in the national capital, but Dublin benefits from the operation of the Homeless Agency, which has brought cohesion, certainty, structure and coordination to homeless services. The agency does not operate outside the greater Dublin area and there, the evidence of a continued persistence of homelessness is compelling.¹⁸

Taking a long-term perspective, a reduction in homelessness in the Dublin area almost two decades after the Act was signed by the President is a modest enough outcome. But it is fair to say that it would have achieved much more, had it lived up to the hopes expressed for it by Minister Flynn at the time. The minister made it clear that the local authorities had responsibilities that they could discharge in a number of different ways, but they must still discharge them. In other words, doing nothing was not an option. In effect, the 1988 Act enabled the local authorities to proceed with the accommodating of homeless people into housing, with the expectation that they would do so.

With the exception of the The MakeRoom campaign, a surprising feature of the current discourse on homelessness in the voluntary and community sector concerned with homelessness is the relatively low visibility of a rights-based approach. In 2007, it was announced that a new Housing (miscellaneous provisions) Bill would be introduced to update a number of aspects of housing legislation. This would be an opportunity for a reconsideration of the issue of obligation, the most contentious aspect of the 1983, 1985 and 1988 Bills. There is little sign, though, of such a reconsideration being opened. In some respect, this may show maturity on the part of the voluntary and community sector in not embarking on a futile political campaign. The Disability Bill, 2001 and the case of Sinnott show just how hostile the Irish courts and governments are to rights-based approaches within law, politics or administration.¹⁹

But is it maturity? In one of the most stimulating commentaries on the role of the voluntary and community sector working with homeless people, Phelan and Norris alert us to the danger that this homeless sub-sector has been a willing accomplice to its own political neutralisation through a combination of funding, professionalisation and suffocating social partnership.²⁰ The reduction in numbers homeless in the national capital were achieved at a time when Ireland was going through a period of prolonged economic growth in the course of which it became the richest nation state in the European Union.²¹ These gains could prove to be quite ephemeral in the event of a period of what is euphemistically called 'below trend' economic performance in the future. Maybe now it is time to respond to minister Flynn's invitation issued 20 years ago.

16 The formal count of homeless people shows 5,581 homeless in 2002, falling to 2,399 in 2005.

17 Eoin O'Sullivan: Reducing homelessness in the Republic of Ireland - policies and processes. Paper presented at the seminar on homelessness research in Europe, September 21-22 2005, Socialforskningsinstituttet, Copenhagen.

18 For example, Barry Roche: Homelessness in Cork increasing, says Simon, Irish Times, December 24 2007

19 Gerry Whyte: Social inclusion and the legal system - public interest law in Ireland. Dublin, Institute of Public Administration, 2002.

20 Elaine Phelan & Michelle Norris: Neocorporatist governance of homeless services in Dublin - reconceptualisation, incorporation and exclusion. *Critical Social Policy*, vol 28, §1, 2008.

21 Ireland's income per head rose from 70% of the European average in the 1970s, at the start of our story, to 144% by 2008 (Eurostat figures).



CHAPTER 2

RESEARCHING HOMELESSNESS IN IRELAND: EXPLANATIONS, THEMES AND APPROACHES¹

EOIN O'SULLIVAN²

Introduction

The aim of this chapter is to briefly describe and summarise research conducted into homelessness in the Republic of Ireland since 1970. Prior to this period, little is known about the extent, nature or composition of the homeless, although references to the number of homeless using county homes can be found in The Report of the Commission on the Relief of the Sick and Destitute Poor, Including the Insane Poor in 1928³, the annual reports of the Department of Local Government and Public Health until 1945 and from that period, occasional references to these persons in reports not directly concerned with their situation (e.g. Care of the Aged Report 1968). No government department had direct responsibility for the homeless and as a result, little information is available on the extent of homelessness or the State's response to the homeless. Although a range of voluntary agencies provided services to the homeless, primarily in the form of large institutional hostels, little information is available on the activities of these agencies before 1970. From the early 1970s, homelessness became increasingly visible, particularly in Dublin, partly attributable to the gradual decline in the continuum of institutions that had traditionally housed the homeless – psychiatric hospitals, county homes, industrial schools (for an overview of the role of these institutions, see O'Sullivan & O'Donnell 2007) – but also attributable to the energetic efforts of a number of voluntary agencies, founded in the late 1960s to provide both services to the homeless and to campaign on their behalf. These agencies, particularly the Simon Community (later joined by Focus Point, the National Campaign for the Homeless, the Streetwise National Coalition) initiated a number of pioneering research projects and contributed to shifting the public understanding of homelessness from a largely individualistic understanding of homelessness to a broader structural explanation. In the mid-1990s, the establishment of a Homeless Initiative in the greater Dublin region (later to be replaced by the Homeless Agency) led, amongst other achievements, to a plethora of research on the extent of homelessness in the region, the efficacy of various models of intervention and detailed evaluations of service provision.

Methodology

Between 1970 and 2008, 128 publications on aspects of homelessness in Ireland were identified. Excluded from this figure are publications, which whilst mentioning homelessness, are not primarily concerned with homelessness. Conference papers, Annual Reports, submissions to Government and other 'grey' literature not available in either the National Library of Ireland, or specialist libraries such as that maintained in the Homeless Agency, Combat Poverty Agency or the Health Research Board, are excluded. The various assessments of homelessness conducted periodically by the Department of Heritage, Local Government and Environment are also excluded, as they are merely compilations of administrative data. Likewise, information on the extent of youth homelessness contained in the Interim Minimum Datasets compiled by the Department of Health and Children and in the Reviews of the Adequacy of Child Care Services compiled by the health authorities are excluded for the same reason.⁴ However, the three surveys of homelessness in the greater Dublin region are included as the data are checked and validated in addition to drawing on primary as well as secondary data. The inclusion of the 128 publications and the exclusion of others is a broadly subjective assessment on my part, and there is no doubt that another researcher might have compiled a somewhat different list. Similarly, the

¹ I would like to thank Shane Butler, Brian Harvey, Mary Higgins, Paula Mayock and Tony McCashin for their helpful observations on earlier versions of this chapter.

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³ The Report, requested the Garda Síochána to carry out "a census of homeless persons observed wandering on the public highways in a single night in November, 1925". They arrived at a figure of 3,257 homeless persons, of whom 901 were children.

⁴ In addition, the strategic plans on dimensions of homelessness published from the early 2000s and the Fitzpatrick review of these strategies are excluded, as they arguably do not constitute research per se. Also various commissions and committees such as the Ad-hoc Committee on homelessness, which was established in 1983 under the aegis of the Department of Health is excluded. This was established primarily 'because health boards reported finding an increasing housing element in the problems coming before them when dealing with homeless people. The boards also found themselves in disagreement with the housing authorities over their respective responsibilities'. Also excluded is the short Lord Mayor's Commission into Homelessness in Dublin that was established in 1993 in response to the deaths of a number of homeless people in Dublin.

classification of the publications might well be different if embarked on by someone else. The classification of research in terms of themes, methodologies and theoretical perspectives is particularly problematic as many research projects embrace more than one methodology i.e. they use both qualitative and quantitative methods, and more than one group of the homeless, i.e. homeless adults and homeless young people. In categorising the publications along these dimensions, the somewhat crude corraling of the research was determined by the primary methodology or group outlined and described in the research. This review is not a meta-analysis of the results of the research identified, rather, it more modestly aims to identify the focus, methodology and theoretical perspectives evident in the work. In the spirit of academic collaboration, the spreadsheets containing the classification of the research are available from the author.

Overview of research into homelessness in Ireland

As shown in Table 1, research into homelessness has developed slowly since the early 1970s, and the number of publications on aspects of homelessness has increased in every subsequent decade. In the 1970s and the 1980s, the bulk of the research was conducted and published by various voluntary agencies, whereas by the 2000s, the bulk was commissioned and published by the Homeless Agency. Nic Ghiolla Phadraig (1972) in her bibliography of social problems and social services in Ireland in the early 1970s did not record any research explicitly concerned with homelessness. This slow development of research into homelessness in Ireland in part reflected the infancy of disciplines such as sociology and social policy, and in particular the practice of applied social research in Ireland. In a review of social research in Ireland in the mid-1960s it was noted that while '[a] large area of Irish public administration is concerned with social questions, and a substantial amount of public money is each year spent on social services ...[i]nto these areas there has been little research' (Friis 1965: 7)⁵. By the late 1980s, despite an increase in the number of academic posts in the social sciences in Ireland, the funding of social research remained weak (O'Dowd 1988), and proposals to establish a social research council were only realised in 2000 with the establishment of the Irish Research Council for the Humanities and Social Sciences.

Table 1: Decade in which research was published

	No	%
1970s	9	7.0
1980s	26	20.3
1990s	40	31.3
2000s	53	41.4
	128	100.0

Irrespective of the decade in which the research was published, the majority of publications that reported on primary research are focused on Dublin (see Table 2). Only very limited primary research has been conducted in the other four major cities, and even less so outside these urban centres (see O'Sullivan 2006 for an overview of research on homelessness in rural Ireland).

Table 2: Location of the research

	No	%
Dublin	71	55.5
Outside of Dublin	16	12.5
National	41	32.0
	128	100.0

As noted above, the bulk of research into homelessness during the 1970s and 1980s was both commissioned and published by voluntary agencies and, despite the substantial output of publications from the Homeless Agency in recent years, the voluntary sector remains an important source of research into homelessness in Ireland. Overall, between 1970 and the present, just over 40 percent of research into homelessness was conducted by voluntary agencies as shown in Table 3, with a higher proportion in the 1970s and 1980s than at present. Nonetheless, Focus Ireland, the Simon Communities, the National Campaign for the Homeless and Merchants Quay were, and in some cases are, the key voluntary agencies working with the homeless who also research the issue. However, it should be borne in mind that while voluntary agencies contribute very significantly to research into homelessness in Ireland, the majority of voluntary homeless service providers do not conduct research. In a

⁵ This report resulted in the Economic Research Institute, established in 1959, expanding its brief to include social research and becoming known as the Economic and Social Research Institute.

limited number of cases, voluntary agencies are either reluctant to co-operate with researchers from other voluntary agencies, or indeed actively hostile to the research endeavour.

The criteria for inclusion in the category 'academic' research into homelessness are somewhat crude. It simply refers to research or reviews of dimensions of homelessness that are published in academic journals or as chapters in academic books. In some cases, particularly so in the case of the extensive publications by Brian Harvey, the author was employed as a research and information officer with the Simon Community, and could equally be placed in the voluntary sector category. While this chapter does not attempt to evaluate the quality of the research output from the voluntary sector, it is probably fair to say that Fitzpatrick and Christian's view that research conducted by voluntary organisations 'can be more concerned with producing effective campaigning material than with obtaining reliable evidence' (2006: 324) also holds true in the Irish case. At the same time, it is also true to say that a number of voluntary agencies consistently pressed state agencies to provide accurate data on the extent of homelessness, and met with only limited success until the passing of the Housing Act, 1988 which required local authorities to provide an assessment of the extent of homelessness in their functional areas.

Table 3: Source of the research

	No	%
Funded and commissioned by the state	40	31.3
Commissioned by the voluntary sector	52	40.6
Academic	36	28.1
	128	100.0

Of significance is that until the establishment of the state sponsored Homeless Initiative in 1996 (later to be replaced by the Homeless Agency), few statutory authorities conducted research into homelessness in Ireland; their only participation in the field was via occasional part-funding and co-operation with research conducted by voluntary agencies. This has changed, at least in the greater Dublin area, but outside of Dublin, statutory bodies have provided limited support for research into homelessness.

Focus of research

The majority of the published research on homelessness has focused on homeless adults, as shown in Table 4, generally the single adult homeless, this being particularly the case in the 1970s and early 1980s. By the late 1980s detailed and pioneering research on homeless women and homeless children/adolescents had emerged and in recent years, a more heterogeneous range of sub-populations within the overall homeless has emerged in the literature. It is difficult to determine the degree to which research emerged in response to a growth in, for example, homeless children or the degree to which research constructed the sub-population. Given that, as noted above, the bulk of research into homelessness was conducted by voluntary agencies with explicit campaigning agendas, it is likely these categories reflect in part these agendas.

Table 4: Focus of the research

	No	%
Homeless young people	25	19.5
Homeless adults	87	68.0
Homeless women	6	4.7
Homeless families	10	7.8
	128	100.0

Table 5 attempts to classify the research to-date in terms of the substantive aspect of homelessness explored in the research. The single largest category is 'policy review/evaluation'. This is a somewhat catch-all category, which includes many academic commentaries on homelessness, and much of the research output of the Homeless Agency. Research focused on enumerating homelessness accounted for one-fifth of the research over this period reflecting the long-standing debate over the extent of homelessness in Ireland.

Table 5: Aspect of homelessness explored

	No	%
Extent of homelessness	25	19.5
Health, services and other needs	23	18.0
Addiction	7	5.5
Mental health	10	7.8
Conflict with the law	6	4.7
Policy review/evaluation	52	40.6
Autobiographical	5	3.9
	128	100.0

Theoretical and methodological perspectives on homelessness in Ireland

If a dominant paradigm existed in the limited literature on homelessness in the early 1970s, it was that homelessness could be understood as a process of disaffiliation⁶ from society because of the individual deficits of the homeless themselves. As the numbers of homeless grew during the 1980s, particularly in the United States, but also in many European countries, individualistic explanations become increasingly difficult to support, and structural explanations came to the fore highlighting the impact of changes in the labour and housing markets, in addition to welfare state readjustments as drivers of the increased homelessness. While structural accounts were a necessary corrective to the individual pathology explanations, they in turn failed to adequately explain why only some households who found themselves exposed to growing unemployment, increasing poverty and a shortage of affordable housing became homeless. In recent years, social science research on homelessness has increasingly come to understand homelessness as the outcome of a dynamic interaction between individual deficits and structural change (Anderson and Christian 2003)⁷.

In addition, as research into homelessness became methodologically more sophisticated, moving away from cross-sectional or point-in-time surveys to longitudinal approaches, researchers became increasingly aware that households moved into and out of homelessness on a more frequent basis than cross-sectional studies previously revealed. Cross-sectional research, primarily utilising structured face-to-face interviews, provided information on the 'demographics and disabilities' (Snow et al. 1994: 462) of the homeless, but in the process distorted the reality of the situation. These distortions arose from four methodological and interpretative tendencies in the research: the very nature of cross sectional research, the inappropriate use of instruments of psychiatric evaluation, the medicalisation of the issue and the absence of a contextualising framework. Consequently, much of the existing research gave:

...a truncated, decontextualized, and over pathologized picture of the homeless, a picture that tells us relatively little about life on the streets as it is actually lived and experienced and that glosses over the highly adaptive, resourceful, and creative character of many of the homeless, some of which may in fact be mistakenly perceived as pathological (Snow et al. 1994: 469).

Not only did methodological limitations of cross-sectional research generate results that distorted the reality of homelessness, in addition, cross-sectional research, according to Wong (1997: 13), 'has little relevance to social policy making because of its inability to identify antecedents that may be associated with the duration, ending, and recurrence of homelessness'. Thus, the host of factors that can result in individuals entering homelessness were not necessarily the same as the factors that resulted in individuals remaining homeless or, indeed, exiting homelessness. Furthermore, since cross-sectional studies over-estimate the severity of homelessness, those who are long-term or chronically homeless tend to be overrepresented. Emerging longitudinal research clearly highlights the dynamic nature of homelessness and demonstrates that the majority of individuals both enter and exit homelessness relatively speedily. In broad terms, three sub-sets of the homeless population can be identified: those who are long-term users of emergency services and/or rough sleepers; those who have ongoing episodic bouts of homelessness and those who experience temporary homelessness, but rapidly exit and do not return to homelessness (Culhane and Metraux 2008).

By the beginning of the 21st Century, homelessness was increasingly viewed as an objective condition that could occur for a much greater number of households than envisaged some 20 years earlier, if both individual deficits

6 The leading exponent of this perspective was Howard M. Bahr and his associates. His formal definition of disaffiliation was 'homelessness is a condition of detachment from society characterized by the absence or attenuation of the affiliative bonds that link settled persons to a network of interconnected social structures' (1973: 17).

7 One of the reasons for the disjuncture between studies that highlight personal inadequacies as the principal explanation for homelessness and those which privilege structural explanations is in part explained by the unit of observation. Studies that focus on homeless individuals as the unit of observation tend to find personal inadequacies predominate, whereas studies that focus on rates of homelessness tend to find that structural factors, in particular housing factors such as vacancy levels or rent levels dominate (see O'Flaherty, 2004 for further details).

and structural adjustments interacted in a specific manner. The majority of homeless households exited this state reasonably quickly, but in some cases experienced a series of further short-term homeless episodes. Others remained homeless for longer periods and this appeared to be exacerbated by individual deficits, particularly poor mental health and a lack of employment history or through negative state interventions such as imprisonment, particularly for males.

To date, few studies of homelessness in Ireland have attempted either to formally test explanations for homelessness developed elsewhere, or to generate new theories of homelessness. The research that has utilised explicit theoretical perspectives of homelessness has, by and large, drawn on perspectives in vogue at that time, particularly models developed in the UK and the US. For example, O'Brien (1979) and O'Sullivan (1993) draw heavily on the symbolic interactionist framework deployed by Archard (1979) in his study of skid row in London. The concept of disaffiliation is evident in the work of Kearns (1994) and O'Brien (1982). More recently, research on youth homelessness has utilised a pathways approach (Mayock & Carr 2008, Mayock & O'Sullivan 2007, Pillinger 2007) drawing on the work of Clapham (2003) and Anderson and Tulloch (2000). Drawing on broader ideologies of welfare many commentators have argued that the Irish polity has enthusiastically embraced neo-liberalism and this can be evidenced by the growing range of social ills, exemplified by the increasing commodification of housing (see for example, Drudy & Punch 2005). Drawing on these broader critiques of the changing governance of welfare in Ireland, Phelan and Norris (2008) have characterised the structure of the delivery of homeless services in Dublin, under the ambit of the Homeless Agency, as neo-corporatist and driven, albeit not entirely, by the dictates of neo-liberalism. These developments have resulted, according to the authors, in an:

'over-emphasis of the individual causes of homelessness and consequently on controlling the behaviour of clients, coupled with the failure to put in place all of the supports necessary to enable homeless people to access relevant services, has excluded a minority of 'challenging' clients from access to homeless services in Dublin or stymied their progress along the continuum of care from emergency to transitional and ultimately to long-term housing' (2008: 68-69).

It is not clear how the authors square the neo-liberal intent of the Homeless Agency with the substantial increase in funding for homeless services, particularly transitional housing. More significantly, the exclusion of individuals with 'challenging' behaviour is not novel; if anything, with the development of a specialist services such as 'wet hostels', and the requirement that explicit reasons need to be given before an individual is excluded from homeless services, less individuals are excluded than was the case in the recent past. Before the establishment of the Homeless Agency active drug users, heavy drinkers, couples and others with challenging behaviour were largely excluded from homeless services. Neither does the view expressed by the authors that the Homeless Agency 'over-emphasised' the individualistic causes of homelessness stand up to objective scrutiny when the various publications, particularly its strategic plans, are examined.

Not surprisingly, the research that does draw explicitly on theoretical models, in the main, emanates from within academia, rather than voluntary agencies or other governmental bodies. It is also worth observing that those employed in schools of social policy, social work and applied sociology produce the limited academic research on homelessness in Ireland. This is somewhat similar to the UK, where Fitzpatrick and Christian (2006) note a similar dominance by social policy academics, but in the case of the UK, the academics have roots in the field of housing studies⁸. This applies in only a limited manner in Ireland, due in part to the absence of any well-developed discipline of housing studies. In the Irish case, the academic backgrounds of many commentators, albeit diffuse, tend to be in social policy, social work/social care and advocacy. While occasional contributions have come from the disciplines of law (Maher 1989), criminology (Seymour & Costello 2005) psychology (Hart 1978, O'Leary et al. 2003) and medicine, particularly psychiatry (e.g. O'Neill et al. 2007), the topic has attracted very limited interest from economists, anthropologists or geographers.

In broad terms, the dominant theoretical paradigm in homelessness research in Ireland can be described as 'social reformist' and this, as noted above, reflects the dominance by voluntary agencies and social policy academics in homelessness research in Ireland. Thus, a key concern has been on enumerating the homeless, identifying their needs, and proposing remedies to alleviate their distress. However, because of the social reformist agenda, many felt compelled to dramatise the extent and needs of the homeless and, as a consequence, definitional and methodological issues were not as rigorously debated as they should have been

⁸ In the US, Fitzpatrick and Christian (2006) suggest that psychological and medical perspectives dominate homelessness research, with only limited input from the social sciences.

and pressures exist to come up with a variety of 'right answers' (Shlay & Rossi, 1992: 153). One outcome of this lack of a definitional consistency was the difficulty of generating an accurate portrait of homelessness. Reviewing a number of research reports on aspects of homelessness funded by the Combat Poverty Agency in 1990, Daly (1990: 19) noted that researchers were using differing definitions of homelessness and this rendered problematic any attempt to generate a composite picture of homelessness in Ireland.

The vast majority of research into homelessness in Ireland has tended to explain homelessness in structuralist, rather than individualistic terms, particularly research emanating from the voluntary sector⁹. Structural explanations locate the reasons for homelessness in social and economic structures and cite poverty, negative labour market forces, cuts and restrictions in social welfare payments and reductions or shortfalls in the supply of affordable housing as the leading causes. Individualistic accounts, on the other hand, focus on the personal characteristics and behaviours of homeless people and suggest that homelessness is the consequence of personal problems, such as mental illness and addiction.

Reviewing the literature on vagrancy in Britain at the end of the 1970s, Archard (1979: 19-20) concluded that '[o]ur understanding of the problem has been reduced to statistical and demographic distributions of the problem. Almost without exception, whether the rationale be the medical and social treatment, the social administration of the problem, or the extent of vagrancy in contemporary Britain, studies have been reduced to crass empiricism, devoid of any articulate and specific theoretical framework'. This situation was partly rectified some 20 years later when Anderson (2003: 198) could report that a range of theoretical perspectives, from Marxism to social constructionism, had been applied to research in Britain. Anderson also observed that various surveys of the homeless had paid insufficient attention to issues such as sample size and composition and consequently, were limited in terms of drawing generalizable conclusions.

In the case of Ireland, such a development is not evident. This is partly explained by the lack of sustained academic interest in the issue of the homeless and the restricted disciplinary basis of those who have explored the topic. In terms of the primary methodology employed in studies of homelessness in Ireland, quantitative methods dominate, followed by policy analysis, with qualitative and ethnographic methodologies only rarely utilised. The bulk of the quantitative research has been concerned with counting the homeless and describing their characteristics. To date, all have been cross-sectional in their approach and the only longitudinal research is qualitative in approach, drawing on a relatively small sample (Mayock, Corr & O'Sullivan 2008). The limitations of the methodologies employed to date in Ireland were highlighted above, resulting in a partial and misleading understanding of homelessness in Ireland.

Table 6: Primary methodology employed in the research

Secondary data analysis	12	9.4
Policy analysis	43	33.6
Qualitative data analysis	13	10.2
Quantitative data analysis	55	43.0
Ethnographic	5	3.9
	128	100.0

This situation is not unique to Ireland. Snow and Andersen (1991: 150) observed when reviewing the vast output of research on homelessness during the 1980s in the United States that: '[m]ost are based on questionnaire surveys of the homeless or shelter providers, and most are concerned primarily with the demographics and disabilities of the homeless'. They further argue that '[t]he tendency to focus on the demographics and disabilities or pathologies of today's homeless is also readily evident in both the popular and social science literature. Indeed, it is difficult to find current research on the homeless that goes much beyond enumeration of their demographic characteristics and of the disabilities or problems they are thought to have, such as mental illness, alcoholism and poor health' (1991: 151). A number of years later Snow et al argued that much of the existing research distorted the lived reality of homelessness. This they contended was because of 'tendency to infer patterns from strips of behaviour based on a single encounter in a single situation, by the tendency to use uncritically the instruments of psychiatric evaluation and diagnosis, by the tendency to invoke and think in terms of the language of disability and medical perspective with which it is associated' (1994: 469).

⁹ One exception to this general observation is the popular account provided by Leahy and Dempsey (1995) of the emergence of Trust, a voluntary agency providing medical and other services to the homeless in Dublin. In addition to detailing the history of the organisation, a case study of one man's descent into homelessness and his eventual exit is provided. Poor relations with the man's father, his experimenting with homosexuality and engagements with religions other than the Catholic Church are all implicated in his descent into homelessness. His exit from homelessness is largely achieved through rejecting homosexuality, embracing Catholicism and making contact with Trust

Conclusion

Measured purely in terms of the number of reports, books, book chapters and journal articles produced, research on homelessness in Ireland is more vibrant today than at any point over the last 30 years. Much of this increased output, particularly evaluations of service provision, is driven by the Homeless Agency, which by the nature of its remit conducts research into homelessness only in the greater Dublin area. Even before the establishment of the Homeless Agency, research was skewed towards Dublin and our knowledge of the dynamics of homelessness, however limited in the greater Dublin area, are even more limited outside the capital. Methodologically, quantitative cross-sectional approaches dominate and a broad consensus exists internationally that such approaches can distort our understanding of homelessness and hence policy solutions. This is of particular concern when, as is the case in Ireland, the research is driven by a social reformist agenda. Policy options in relation to homelessness may be influenced by research, although this is not necessarily the case, but in the off-chance that it might be, researchers need to at least ensure that the research is methodologically robust, incorporates a longitudinal element to track the dynamic nature of homelessness, and base recommendations on the research evidence rather than the ideological perspective of the commissioner.

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HOMELESS POLICIES AND SERVICES: MAKING ROOM FOR THE PERSON

JOHN-MARK MCCAFFERTY

Introduction

Financial resources, the obligations of local authorities and the HSE¹, and a constant debate about numbers of people who are homeless often dominate discussion within the homeless sector. The Vincentian Housing Partnership (VHP), however, is built on an ethos of friends and relationships. Consequently, this chapter provides a 'softer' focus to the homelessness debates and discussions by centring on the person and some of their core personal needs, fears and resources. It will explore some of the 'affective' and interpersonal needs and capabilities of people in transitional housing in terms of care, relationships, and their sense of being needed or wanted in the systems they inhabit. The chapter will attempt to provide a small insight into the lived experience of homelessness and homeless service provision, and some of the relationships and supports that exist in that context.

The chapter aims to transcend the current 'buzzwords' and trends in the homeless sector and to instead examine the relationship-side of homelessness. This aim arises partly as a result of the ethos of the organisation for which I work. The Society of St. Vincent de Paul offers companionship and support, assists in building self-sufficiency and empowerment and advocates for social justice. In the spirit of this Vincentian ethos, the chapter asks deeper questions about identity, self, truth and justice. Mobilising personal resources and relationships may enable a person to overcome the experience and effects of homelessness, but doing so requires a certain degree of self-esteem and feeling of empowerment. These will thus be explored to examine how they may relate to the processes leading to homelessness and the experience of being homeless. Insight from service providers and volunteers on the roles and influences of the homeless sector, the government, society and personal relations will also be considered.

A lightweight ethnographic approach

I will be using the phrases Rendu, Vincentian Housing Partnership and VHP interchangeably to describe the voluntary housing organisation in North William Street where I spent some time in March and April 2008 talking with clients, staff and volunteers. Their perceptions and experiences will inform my own understanding of living through homelessness. In the process of doing so, I will provide a lens through which the reader can examine his or her notions of what it means to be homeless. The study is very small, is qualitative in nature and does not attempt to make statistical conclusions. It does not attempt to be a comprehensive study on the experience of homelessness, nor claim to be the voice of the homeless person – only people who are or have experienced homelessness can do that. Indeed, the paper is written without a significantly in-depth knowledge of the homeless policy context, and to some extent this is a benefit. It allows an analysis that is not necessarily steeped in a particular framework or paradigm, and is more concerned with the perceptions, feelings and experiences of clients and of staff. In terms of client profile, those interviewed were single males. The staff and volunteers interviewed made observations about clients across the board, both male and female, and those who are single and those in families.

¹ Health Services Executive, the national health delivery body for the Republic of Ireland.

Rendu: The focus of the study

The Vincentian Housing Partnership is a voluntary transitional housing service in the north inner city of Dublin. It opened in 1995 and provides supported social rented accommodation for people aged 20 to 50 who have experienced homelessness. The board is drawn from a partnership of the Daughters of Charity, Vincentian Fathers and the Society of St. Vincent de Paul. Rendu utilises a mix of both volunteers and staff to link in with and support people in their accommodation. The support comprises of key-working, befriending and the development of certain life and social skills. Clients with Rendu stay for 18 months and throughout that time are being orientated towards moving on to more independent, while still supported, living. In order to facilitate this, a contract is drawn up between the client and Rendu, where clients are asked to identify three things they wish to be able to do on their own by the time they reach the 18 month limit. The contract includes agreements around behaviour, respect and personal responsibility. Staff and volunteers talk of a number of principles underlying the service:

A stable environment for clients.

Honesty, openness and a consistent message with clients.

Trust: clients are given a key to their own apartment and this allows for self-belief in the key holder. An open door policy for clients who have moved on, providing practical and social supports for them where appropriate.

The Vincentian Ethos of 'friendship', of 'being neighbour' to clients, including a companionship role for volunteers in the lives of clients.

Transparency, for example where a letter goes to authorities regarding a client, they will see the letter about them before it goes to the relevant agency.

A Christian response to need and a sense of developing 'right relationships' between people.

Impressions of homeless policies

There is recognition within the sector that service user participation is a key, and perhaps essential, ingredient to a model of service provision that values the client and promotes agency and ideas of empowerment. Insight into the feelings and perceptions of homeless clients around allocation, access and policy are central to further advancement of this model.

When asked to what extent the needs of homeless people are at the centre of Irish homeless policy and services, the perceptions of clients vary from those of service providers. Whereas some Rendu staff members and volunteers felt that clients are overlooked when they don't fit into a particular box – and many people don't because they have a variety of complex needs – other staff members maintained that clients are more or less at the centre of policy and services and referenced statutory supports including: more homeless people being asked to feed into policy in general; the Homeless Agency and their policies and Housing Needs Assessment and care and case management protocols being focused on the service user; and government's commitment to ending rough sleeping and long-term homelessness by 2010, as advocated by the MakeRoom homeless campaign².

However, staff noted that resources do not follow up the strategies and gave the example that the HSE is not making any additional development funding available in 2008. In one staff member's opinion, the problem did not lie with the focus of the policy and services themselves, but with implementation on the ground. He cited the historic dearth of social housing and the lack of stock available to house the people scheduled to leave transitional housing in 2008. Lastly, a continued imbalance was identified between the greater availability of emergency accommodation relative to long-term housing.

² MakeRoom is a coalition of four national voluntary organisations working to eliminate homelessness. The Coalition advocates for policies to ensure that, among other things, no one will live in temporary accommodation for longer than is necessary by 2010.

These thoughts were echoed by the service users, although without as much direct mention of policy initiatives. One client was on a social studies course and expressed his belief that more transitional housing, such as that provided by the Vincentian Housing Partnership, should be made available. He also held the view that people moving into a place of their own needed continued staff supports so that people don't stay 'in their own head', socially isolated for prolonged periods of time. He pragmatically stated his opinion of government's approach to drug treatment:

'Government know that the majority of drug users go back to drugs so they think, what's the point?'

In this regard, another client held similarly pessimistic views about government policies towards homelessness. He was adamantly opposed to exercising his vote and cited marches against homelessness that went to the Dail. He felt that the marches had taken place but that as there was still homelessness, the engagement with government on these issues still did not deliver an end to homelessness. The objection to democracy by these two homeless people may denote an absence of rights and a lack of incorporation.

Interestingly, Rendu staff members said that few homeless people made the connection between policy and themselves, did not vote, but viewed social welfare and housing as resources and entitlements. The clients mentioned above did, however, have views on government. The client/staff perceptions differed both in this area and also in terms of how included clients felt within services. This is explored in section five below.

Perceptions of service provision

While the effects of policy decisions made by government affect the lives of homeless people, so does the actual provision of homeless services. The impressions of service users are thus essential to being able to strike a balance between service fatigue and service user participation. One client noted he felt his needs were at the centre of services given the range of supports he availed of including key-working, and a sense that his views were 'being heard and trusted'. This view, however, was juxtaposed by a client who felt he had been asked for too much information by a wide variety of people, including the media. 'All I seem to be doing is answering questions', one client said. Consequently, it benefits the services and therefore the clients, to ask what people who are homeless think about services – but obviously in a manner that does not further burden or indeed disillusion them.

One client talked about feeling cared for, and that it could be a 'weird' experience if there was 'too much caring', in terms of many different professional support people around them. At the same time, this person talked about feeling wanted and acknowledged that he needed and received support when recovering from addiction. In his opinion, the best path for addicts who were homeless is exactly the path he had been able to access: treatment, an aftercare house, transitional housing and housing with supports (the latter he was scheduled to access in the next couple of months). The availability of day services that provided lunch, access to accommodation and key-working were named as other examples where clients felt included or catered for within services. The converse of this is where people were excluded from services. Homeless related facilities that close at a particular time of day, resulting in people being on the streets, was named as a problem for clients. Clients wanted to be housed with the local authority and accompanied by appropriate health and social supports. One client expressed a sense of entitlement to progression through the various homeless and housing supports: 'I want something at the end of this, I've worked hard, so I'm hoping for a house from Respond or RAS or similar.'

However, when Rendu staff members were asked how included or wanted homeless people feel by homeless services, some said that homeless people recognised Dublin City Council (DCC) as a homeless or housing service, but did not feel wanted by it. Staff believed that some clients felt overlooked in terms of city council decisions on housing allocations, and may even be afraid of DCC due to the power they saw it having in that function. For example, a number of clients were angered and threatened by what they perceived as 'outsiders' (such as families with refugee status) getting access to social housing. In addition, the city council had indicated to staff that fewer people from transitional housing were ready for social housing than Rendu believed, and this has caused tension between the sectors. Furthermore, staff identified a subset of clients that did not 'fit' into a specific service as a result of the multifaceted nature of their issues, usually including mental health, and the stigmas attached. Staff believed that this group felt very unwanted by services, especially compared to drug users, for example.

There were clients, though, who staff believed felt welcome and safe with DCC. These clients saw their housing as a place of stability and security, especially compared to previous homeless experiences. Staff also talked of how at Rendu, in particular, clients are included in discussions regarding the recording of their progress as well as in evaluations of services.

Nevertheless, previous experiences influence a client's perception of services provided at Rendu. Many clients were reported to be initially hostile of the high level of supports provided in Rendu because some come from emergency shelters with different approaches and thus regard the Rendu services as being interfering or invasive. Staff maintain that this is usually a phase, and once over this, most clients recognise the benefits of the supports such as key-working and supports from volunteers. When a key worker demonstrates to the client that they care and that they are genuine, a sound professional relationship can develop. At the same time, one established client recently complained of 'service fatigue': that he had had enough of client consultation and the various professional interventions he received. He said it was a challenge to keep up with the names, faces and functions of all the staff and volunteer supports he encountered both inside and outside the Vincentian Housing Partnership. Allowing clients to find and maintain autonomy in their lives without becoming isolated may be an objective for the sector.

After their time with Rendu, a number of clients are placed in the private rented sector. Some are unable to settle in the sector due to greater isolation and loneliness than they were used to in Rendu, despite the work with clients to prepare and orient themselves for being on their own a good deal more. Some clients are afraid of the sector and many would rather leave Rendu without accommodation than have to move into it.

Potential links between pathways into and out of homelessness

The fear of moving along the pathway out of homelessness is worthy of consideration because it is a potentially significant threat to homeless clients. The 'fear of independence' may be linked to the four factors identified by Rendu staff members, and often echoed by service users, that not only cause homelessness but also can make it worse: family, drugs and alcohol, fear, and not being treated as adults. These factors align closely with the threats and vulnerabilities faced by people who are homeless as identified by Rendu staff members: mental health, drugs and alcohol, low self-esteem, client relationships with family, friends and neighbours.

Interestingly, the resources and sources of strength that clients and service providers identified correspond with the threats and vulnerabilities that were stated as causing homelessness and preventing people from moving out of homelessness. For example, clients called upon the following resources during their homeless experience: relationships, personal strength, and skills related to both general training and leisure or hobby activities. When asked what the most important factors were with regard to people who are homeless regaining some of their independence, the Rendu staff members listed relationships, personal strength and newfound skills as the resources people who are homeless have called upon to assist them.

As relationships are viewed as both threats or vulnerabilities and sources of resource and strength, the relationships of homeless clients were examined. Similarly, low self-esteem, not being treated as adults, and fear were identified as barriers to leaving homelessness while personal strength and newfound skills were seen as ways out of homelessness. The links between these will thus be examined.

The dual role of relationships

What happens within the family is often the trigger for homelessness and a barrier to leaving homelessness. Dynamics and events within families may trigger addictions or poor mental health, particularly where parents experience either of these, and this can result in further anger, hate and blame within families. Family members are often afraid of other family members and afraid of being hurt again.

People who are homeless are often at the edge of their family, if not completely excluded from them. In fact, a number of Rendu staff felt that at least half of the clients felt excluded by family, and some people could not get in contact with their friends and/or family. For some people this distance from their family may be no bad

thing, particularly where the actions, behaviours and influence of family members were a cause or contributing factor to their homelessness.

In these cases, family can be a source of problems for homeless people. Often they find it hard to cope with their family but also hard to escape from it. If a person's family or partner is involved in risk-taking behaviour, this can be a stressor and an influence upon the client. A person may feel guilty about moving on and doing well. Old friends and family may regard the client's relative success as a betrayal and the person who has moved on may struggle with how they are now perceived by their old peer group. People often learn how to handle their emotions through living within a family, however some people who are out of home may not have had that opportunity. Consequently, events such as birthdays and anniversaries, reminders of a difficult past, can cause a person to regress.

Yet despite the negative impact a person's family may have on them, most people ultimately want to be part of a family regardless of how poorly it may function. Children can suffer as a result of all of this, but can also be key to a parent's progress. For example when a parent begins to recover from addiction they gain more access to their children and start on the path of regaining custody. One staff member felt that this was a great incentive to continue on the path of independence. Similarly, one client was seeing family once a week after a period of not seeing them for some time, another was in contact with a brother. Family was important to a client who had come off drugs and was more able to be honest with and talk to his family. A significant family member that cared about him and kept in regular contact with him was also identified: 'I'm bonding with family members again', he remarked.

For some people their friends became their new family. Similar to family, friends can have a positive or a negative influence on us all. Sometimes, neighbours within the Housing Partnership give each other a hard time for small but persistent things such as talking too much. Such clients may leave themselves open to confrontation with others. Conversely, one client talked of the tremendous resource that particular friends were in the context of the aftercare experience in addiction services. This person felt that people coming off a variety of addictions supported one another and shared in some form of collective experience in dealing with addiction. The experience of not being able to hide cravings and vulnerability from the others in the house was seen as a resource. The client reported that he had to confront himself, and the need for honesty with themselves and with others was a period of real challenge but also growth. The same person talked about friends but made an interesting distinction regarding 'friends who don't take drugs'. He gave a very clear 'health warning' from clients around certain friends who were a resource and those who were a threat. Another client talked about socialising with friends and connecting with people other than those within the Housing Partnership as a reason for getting out of the building for a little while.

The same person found psychiatric supports and bereavement counselling to be very important: 'otherwise I'd be totally lost'. Key-working is available in a variety of settings and 'helps me move on from being homeless. They are supportive' a client remarked. Key-workers featured prominently in the clients' perceptions of important relationships due to the benefits of regular weekly contact, their approachability, the personal sharing with them and the guidance and advice that they could avail of in that relationship. One client talked of the attention to detail that key-workers had such as marking anniversaries. The dependency that may grow out of isolation from friends and family may result in substitutions. While drugs and alcohol are a negative substitution, key-worker relationships are a potentially positive one.

Furthermore, there is a significant pool of volunteers working in Rendu who offer a befriending from of support. Trust and sincerity are key values to the client-volunteer relationship. Interestingly, the small number of clients interviewed did not significantly name the impact of the volunteer. Yet the role of the volunteer is identified by staff and volunteers alike as being central to the ethos of the VHP. Both clients and staff identified the importance of the relationship between 'sponsors' and a person in recovery from an addiction. The sponsor tends to be in recovery for a number of years themselves and provides contact and support to the client on a regular basis.

Building social capital and networks is a key to moving out of homelessness and for some clients, Rendu is the point at which they begin to link back with families and reconnect with children. 'Friendships' in the broadest sense include staff and volunteers in Rendu. For example, clients doing literacy with a volunteer may build social

networks that include peers both within the VHP and outside. In the case of both addictions and mental health problems, a person is often overly focussed on themselves to the exclusion of anyone else, according to staff and volunteers. Once a person is able to see how their illness and actions affect others and stops focusing on themselves alone, they are able to begin the recovery process. Furthermore, as people begin to connect with their families again, reconnect with their children and develop healthy relationships with their peers, staff feel that clients begin to see themselves as a part of something bigger.

Self-esteem and 'agency'

Relationships appear to be both positive and negative regarding homelessness. They can cause and exacerbate homelessness, but can also provide sources of support and motivation. In a similar way, 'agency', i.e. personal action or intervention to produce a particular effect, can be a double-edged sword. Feelings of alienation from society and low-self esteem can be barriers to leaving homelessness on one hand, or, by increasing personal strength, they can be a way out of homelessness on the other. Staff commented that at certain times, clients battle with a mixture of fear, anger, resentment and self-hatred.

One client felt that there were a variety of threats facing them 'without looking for them', but that there were more fears than there were threats – that having a level of control over one's mind was a key concern. This was echoed by another client, citing the fear of being homeless again and the anxieties around the death of family members and friends. The experience and the prospect of loneliness was an issue and many fears stemmed from problems with mental health. The clients interviewed regarded fears and anxieties to be causes of erratic behaviour. 'Anything can trigger me', said one client, who observed that they tended to react to negative experiences by physically running away, which they acknowledge caused problems in the longer term. Having one's own apartment can place stress on someone who has previously been homeless because they may be afraid of losing their home and not being given a second chance.

A client's self-esteem may be affected by fearing one's own actions or thoughts and also by feeling isolated from society. One client, an ex-drug user, described society as 'scary'. 'It's hard for me to look someone in the face, because I used to be 'in' myself on drugs – now you care what people think.' The same person was sensitive of the atmosphere in two particular settings: 'deprived areas', where he felt exposed to the 'wrong company', and also crowded city centre spaces where the 'whole world is looking at you'. The sense of being on one's own and making one's way through society was daunting for him: 'Freedom is a scary idea for a recovering drug addict.' Rendu staff members agreed that for the most part homeless people did not feel fully part of mainstream society. According to staff and volunteers, most homeless people are from the inner cities and are only engaged in that local setting, if at all. Clients may feel that they belong to a particular community, whether geographical or of interest, however this 'belonging' exists alongside low self-esteem rather than instead of it. Indeed, where people 'belong' is usually where they have had all their problems. One staff member remarked that a client had recently said to them that they 'felt strange getting on the Luas'³. The issue of a changing, more multicultural society was an issue for one person, who saw it as a form of threat – perhaps to their access to resources, or to a homeless identity, when they said that the Big Issues magazine didn't 'belong' to Dublin people any more because 'all foreign people are selling the magazine now'.

Feelings of alienation and a lack of self-esteem may feed off each other. Staff and volunteers felt that the alienation was partly because society is unaware of the experience of homelessness and the forces and factors involved. Indeed, people may only get mobilised on the issue when threatened with the prospect of homeless people being housed close to them. If housing provision was planned and resourced well, such a scenario would not be a problem. As practitioners and policy specialists well know, a key element of Part V of the Planning and Development Act (2000) was the mix of 20 percent social and affordable housing within new private housing developments. Instead, local authorities have frequently taken money in lieu of bricks and mortar and this was seen among staff and volunteers as a failed opportunity for greater social mix.

Staff and volunteers observed that by the time people had reached the VHP, they had lost a sense of what a 'normal' life was, and were trying to reclaim this. Some staff felt that people in recovery from addiction and without significant mental health problems tended to be more highly functional than those with poor mental

3 The name of the Dublin Light Rail public transport system.

health alone. The clients with addiction were most likely to get involved in hobbies and past times than other clients. Nonetheless, staff believed that recovering addicts still felt outside the social 'mainstream'. Often, a limited education is a barrier to getting a job, and unless people can engage in adult education or gain a role in a local community group, they may feel little connection to 'normal' society.

People can also lose sight of their future if they are not treated as adults. If they are not fully respected in word and deed, with time and effort spent to hear their dreams, aspirations and choices, they stop using the resources being provided to them, and the forces and factors underlying their homelessness will not be tackled. Consequently, working to empower a homeless client and increase his or her self-esteem is highly valuable.

These resources may emerge both from within a person and be taught or coached. One client cited the ability to maintain and take pride in their appearance as a resource. Another client talked about 'momentum' as a personal resource. They described it as follows:

"I worked a lot on myself when I was in treatment, and I'm maturing. My frame of mind can change day to day – I've just to make sure not to use the 'fuck up' button. It's the mind that needs to be managed. You have to remember that you have some control, that's the most important thing when your confidence and self-esteem is low."

Having a focus of some sort, be it family, children or college, can help a person to find the commitment and determination to keep them going. For staff, the key was restoring a client's faith in themselves and assisting them in rebuilding their self-esteem. Staff and volunteers identified a number of ways to do this: counselling, consulting on the steps of their recovery process, and helping the person to see that they are good people, worthy of being loved.

Learning skills and developing a routine allows all of us, including people who are homeless, to take greater control of our lives. While in Rendu, clients learn to budget, cook and access services and entitlements as part of their tenancy. They are encouraged to save money with a credit union where possible. Other skills developed include preparing a CV and social skills such as being a responsible neighbour and building regular routines regarding medical and dental visits. The key supports mentioned by staff are the Foundation programme adult education course with the VEC in Parnell Square, including courses as diverse as literacy and numeracy, social studies, cooking and yoga; and social welfare supports such as the Community Welfare Service and the ability to work so many hours on Community Employment before losing any entitlements.

The last area identified as a way of building personal strength was leisure activities including sport – both watching and playing, and the gym. The latter was a very recent hobby for one person who tried it, liked it, and found the routine of the activity a very helpful resource in itself. 'Now my days are filled with good things' this person commented.

Key themes

A number of main themes arise from the time I spent with clients and staff in Rendu. Informal relationships with family and friends are particularly ambivalent in the lives of clients. What appears to be wholly positive is the professional key-working relationship in the VHP and other services. Key-working and volunteer supports are manifestations of the Vincentian ethos of 'friendship' in Rendu as identified by staff and volunteers themselves. Mental health and addiction are the key threats to self-esteem and personal autonomy or 'agency' among clients. Conversely, there are several resources that clients chose to draw upon in order to empower themselves. In addition to key-working and the more positive 'affective' relationships in their lives, these include developing a range of skills through courses and engaging in sport or leisure.

However, another finding that emerges is the difference in reported perception between clients and service providers. The differences may say something about the unequal power that can exist in any client/service provider relationship. They may manifest in terms of what is and is not said, and what is perceived as the right or the wrong thing to say within the context of a tenancy. Other differences may emerge due to divergent views of one group by the other. For example, the clients appear to feel more included in homeless services generally than the staff tend to believe.

Conclusion

In the spirit of the Vincentian ethos outlined at the beginning of the chapter, I have sought to ask some more fundamental questions about identity, relationships and justice. In so doing, three main narratives have been identified: the ambivalence of relationships in the lives of clients; the threats to self esteem; and thirdly the resources that clients draw upon in order to take a greater level of control in their lives.

Equally interesting are the questions that emerge as a result of the study and these may warrant further examination. Firstly, do people working in the sector fully appreciate the perceptions of clients given the inherent power relationship between service users and service providers? Secondly, do clients perceive that they lack self-esteem, agency or the ability to participate in the processes? And lastly, what mechanisms, if any, can or should be instituted to increase empowerment and service user participation while preventing 'user fatigue'? These questions are currently of particular interest to homeless services operating within the 'Vincentian family', and to those organisations that are members of the MakeRoom homeless alliance.⁴

⁴ I wish to acknowledge the clients, staff and volunteers of Rendu Apartments, without whose permission, openness and enthusiasm this particular set of insights would not be possible. Equally I wish to thank Shea Mahoney's work on collating responses, Caroline Fahey's proof-reading, and Bernadette McFadden's assistance in the structuring of this chapter.

Homelessness and policy matters

Chapter 4:

Paradise lost or found? The changing homeless policy landscape in Ireland

Andrew Brownlee

Chapter 5:

**Homeless policy and housing options in three European countries:
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Isobel Anderson, Evelyn Dyb and Joe Finnerty

CHAPTER 4

PARADISE LOST OR FOUND? THE CHANGING HOMELESS POLICY LANDSCAPE IN IRELAND

ANDREW BROWNLEE

Introduction and context

The homeless policy landscape in Ireland has changed immensely over the past couple of decades. The period has been defined by a number of significant policy developments, each having a notable impact on the way in which homelessness has been addressed by the State. Prior to the Housing Act of 1988, the approach to homelessness largely involved development of ad hoc services by the voluntary sector with some sporadic statutory funding provided at local level. The Act introduced what many still regard as a contentious definition of homelessness. It obliged housing authorities to measure it via triennial Housing Needs Assessments, placing more accountability on local authorities to consider the extent of homelessness in their areas and develop appropriate responses. In the early 1990s, Guidelines were issued that led to the establishment of homeless fora for the five County Borough areas, while the Dublin Homeless Initiative was established in 1996 to provide a more focused response to homelessness across the capital. Despite such developments, there remained a lack of consistency and coordination in homeless service provision, and the first comprehensive attempt by government to address this centrally came in the form of the launch of *Homelessness: an Integrated Strategy* in 2000. This heralded a substantial increase in, and greater coordination of, national funding for homeless services. It led to the establishment of the Homeless Agency in Dublin and the development of formal local strategies across the country, making it more difficult to ignore and 'pass on' the problems of homelessness in some areas.

Five years later, an Independent Review was commissioned that produced surprisingly high levels of commonality and consensus, despite the wide cross-section of statutory and voluntary stakeholders involved. This review concluded that the strategy had been largely successful, with a great deal of consensus across statutory and voluntary sectors about the way forward. This reflected a generally positive mood across the homeless sector at that point, with hope that Ireland was entering a final, 'ending homelessness' phase. Now however, in 2008, much of the optimism has dissipated, and the momentum built up since 2000 appears to have been lost.

In this essay, I will consider how the various developments in policy have affected the way in which homelessness is addressed in Ireland. The experience of conducting the Independent Review of the Implementation of National Homeless Strategies will be reviewed, illustrating how and why consensus was obtained around the critical success factors for tackling homelessness in the future. I will then go on to examine if, some three years later, a significant opportunity has been missed to make real inroads towards the elimination of homelessness in Irish society. Lastly, I will consider what needs to be done now to restore momentum and move towards the still achievable goal of ending homelessness in this country.

Trends in homelessness

One of the major constraints in assessing homeless policy is the simple fact that we do not, nor have ever, been able to truly measure the extent and nature of homelessness in Ireland. Prior to the Housing Act of 1988 there had been no official government record of homelessness in the state, nor had there been any agreement as to

what actually constituted being homeless. Any studies on the levels of homelessness originated from academia or voluntary sector providers of homeless services.

For the first time the 1988 Housing Act introduced a definition in this regard, albeit one that has attracted much criticism from many parties involved in addressing homelessness in Ireland. The Act stated that a person would be considered as homeless by a housing authority 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 reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or

(b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a)”.

The Act also committed the government to undertake a formal housing needs assessment every three years that would oblige each local authority to measure homelessness under this definition. This obligation on city and county councils to provide an indication of the scale of the issue at local level did focus more attention on the matter in some areas. However the major flaw in the Act’s definition, the subjectivity allowed by including the proviso “in the opinion of the authority”, meant that there was limited confidence in the measurements of homelessness that were subsequently produced.

These measurements took place in Housing Needs Assessments completed in 1989, 1991, 1993, 1996 and 1999. The subjectivity of the count in each area made direct comparisons between each exercise problematic, but there was no doubt that the general trend was of increasing levels of homelessness in Ireland, most pronounced between 1996 and 1999, as highlighted below. It was maintained by government¹ that the increase was partly attributable to moving from a one night count to a broader consideration of those who were without home, but it was accepted that there was an urgent need for intervention to address the situation.

Levels of homelessness in Ireland measured by the Housing Needs Assessment 1989 – 2005	
Year	No of persons categorised as homeless
1989	1,491
1991	2,371
1993	2,172
1996	2,501
1999	5,235
2002	5,581
2005	3,031

Source: Housing Needs Assessments, Department of the Environment, Heritage and Local Government

The integrated approach

Government intervention came in the form of the creation of a Cross-Department Team on Homelessness under the auspices of the Cabinet Committee on Social Inclusion. This was in recognition of the fact that homelessness was a multi-faceted problem, requiring accommodation, health, welfare, education and preventative measures in order for it to be effectively addressed. The Cross-Department Team was set the following Terms of Reference to frame its activities:

“To develop an integrated response to the many issues which affect homeless people including emergency, transitional and long-term responses as well as issues relating to health, education, employment and home-making.”

This response came in the form of *Homelessness: An Integrated Strategy*, produced by the Cross-Department Team and published in 2000. The document represented the first formal attempt by government at a

¹ This position was made clear in *Homelessness: An Integrated Strategy*, launched in 2000, where it was stated that the 1999 assessment was “much broader to ensure that all elements of homelessness were recorded”

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coordinated approach to addressing homelessness in Ireland. Based on extensive consultation with voluntary bodies, health boards and local authorities, it examined the existing services and looked at gaps in terms of accommodation provision, health and welfare services and work, education and training support. Perhaps most critically, it also focused on a key barrier to delivering effective homeless services: responsibility for funding particular types of interventions. The strategy clarified that “Local Authorities will have responsibility for the provision of emergency hostel and temporary accommodation for homeless persons as part of their overall housing responsibility. Health boards will be responsible for the health and in-house care needs of homeless persons.” While such positions seem logical and obvious with the application of some common sense, I believe the formal statement of such positions was necessary in order to drive the subsequent development of the homeless ‘sector’. Indeed the statement served as a reference point for development of joint-agency approaches at local level, making it easier to allocate responsibility to relevant statutory bodies. The Homeless Agency document *A Clearer Future: New Funding Arrangements for Homeless Services in Dublin*, later used this starting point to develop a framework for allocating responsibility for funding specific roles and activities to particular parties, creating a valuable decision-making tool for the statutory organisations.

The integrated strategy also acknowledged the importance of interventions designed to prevent homelessness before it occurs. In this regard it contained a commitment to develop and implement preventative strategies, with an overall national *Homeless Preventative Strategy* subsequently published in 2002. This strategy focused particularly on prevention of homelessness for those leaving institutional care, including prison and hospital.

Overall, the 2000 strategy proposed a series of 24 discrete actions with potential to address some of the key issues in relation to homelessness at that time. Among the most important was the establishment of local homeless forums in every county, involving representatives from the local authority, the health board and the voluntary sector. This built upon the setting up of five forums in the County Borough areas following the issuing of Guidelines by the Department of the Environment in 1991. Also crucial was the plan to build on the work of the Dublin Homeless Initiative in order to create “a new joint executive homeless services centre... to manage and co-ordinate the delivery of all services to the homeless in Dublin”, subsequently realised with the formation of the Homeless Agency. This agency and all local homeless forums were charged with responsibility for producing action plans for the delivery of services to homeless persons in their respective areas. This was intended to make it difficult for problems of homelessness to be ignored or ‘passed on’ in certain areas, perceived as a significant issue at that time, with those that ended up in this situation having to go to the major cities to access any form of support.

The strategy also clearly identified areas where homeless service provision needed to expand. It proposed the creation of local homeless person centres in some areas, the establishment of outreach services to target the needs of rough sleepers, the construction of high-support accommodation, provision of additional night-service centres and settlement interventions to facilitate move-on from homeless services. Of course, such an expansion would have inevitable resource implications. However it seems clear to me that the strategy did not shirk from this issue and indeed included a chapter on funding that pinpointed the need for additional commitment in this regard.

An independent review

When Fitzpatrick Associates was commissioned at the beginning of 2005 to undertake the Independent Review of the Government’s Integrated and Preventative Homeless Strategies, it seemed like a highly challenging task. It would require the bringing together of statutory and voluntary sector views around an immensely complex and contentious subject and finding an agreed way forward for the future. The initial feedback received was that there was some distrust between government and the voluntary sector. This was perhaps partly a consequence of the problems caused by the lack of an endorsement of the previous social partnership agreement, *Sustaining Progress*, by some elements of the voluntary sector. This meant that many of the major homeless charities were excluded from the partnership structures, meaning only limited engagement between them the Department of Environment, Heritage and Local Government (DoEHLG), the body in charge of development of homeless strategy. There was therefore some scepticism about whether the review would merely be a government whitewash, with the likely scenario that the key voluntary sector providers of homeless services would find it difficult to endorse the findings. Government was also dubious about whether the

voluntary sector would engage constructively in the process and there was some resignation about it receiving a negative reaction from such quarters regardless of its content.

The prospect of polar opposite views regarding the effectiveness of national homeless policy was thus anticipated. It was therefore felt that the research underpinning the Review should be as comprehensive as possible, with an ethos that any person or party that wanted to input into the study would be given the opportunity to do so. An open invitation for submissions was issued, backed up by an extensive programme of bilateral consultation with key stakeholders. Detailed questionnaires were circulated to all local homeless fora around the country and seven areas were selected for case studies where local authorities, the HSE and voluntary sector providers were interviewed in-depth. Regional workshops were also held in Dublin, Monaghan, Cork and Galway at which three representatives from each area were invited. There was also an exercise to consider the views of people experiencing homelessness, with 33 one-to-one interviews undertaken in this respect.

By the end of this extensive process, the concern at the outset that the Review might turn out to be somewhat of a 'poisoned chalice' had lifted. The highly positive and constructive consultation exercise produced surprisingly high levels of commonality and consensus, despite the wide cross-section of statutory and voluntary stakeholders involved.

The Review was thus able to produce a series of strong conclusions and dynamic recommendations, underpinned by a strong and irrefutable research base. The Review concluded that there had been a major change in the way in which people around the country perceived homelessness and that there was a much closer understanding of the causes of, and issues arising from, homelessness at national and local policy level. There was widespread acknowledgement of the significant increase in government investment in addressing homelessness since publication of the integrated strategy. It was clear that strong working partnerships between key local stakeholders from local authorities, the HSE and voluntary agencies had developed as a result of the creation of the fora, with many important initiatives progressed as a result. There was also recognition that the numbers of rough sleepers around the country had been reduced, many gaps in emergency accommodation provision had been filled and the overall range and quality of services for people experiencing homelessness had increased substantially. Finally, the establishment of the Homeless Agency was found to have played a key role in facilitating greater coordination of funding for homeless services, developing skills within the homeless sector, expanding the long-term accommodation options available and generally enhancing the quality and quantity of homeless services around Dublin.

While it was encouraging that there was general agreement on the progress that had been made since the publication of *Homelessness: An Integrated Strategy*, the most challenging aspect of the review was always going to be reaching a consensus on the issues that remained to be addressed and on recommendations for the future. However there was strong support across both statutory and voluntary sectors at local level on what should serve as the critical priorities for new national homeless strategy and this was reinforced by evidence from consultation with people experiencing homelessness themselves. The DoEHLG then considered the research undertaken and the level of consensus generated and the positive nature of their approach at this stage should not be underestimated. Indeed I feel that the Department deserves significant credit for being prepared to accept the broad thrust of the recommendations, even where there was some scepticism with regard to particular proposals. In fact, many of the findings dovetailed with the Department's own ideas of what needed to be prioritised and I found it highly committed to finding a practical means of more effectively addressing homelessness in Ireland.

While it was acknowledged that progress noted above had begun to make an impact on reducing levels of homelessness in the State, there were still major weaknesses apparent, including limited coordination of funding, an absence of services in many areas and a severe lack of move-on accommodation for people progressing out of homelessness. There were 21 individual recommendations proposed in the independent review, but a number of key themes dominated its content:

- The need to build on the coordinated approach that was being built up at local level with the implementation of formal mechanisms at national level to ensure an integrated approach to planning and resource allocation.

- The placing of homeless action plans on a statutory basis to ensure that issues of homelessness could not be ignored in any area and that a person would have access to the same level of support regardless of where he/she presented as homeless.
- Implementation of a case management approach in all services to ensure effective and coordinated homeless service provision.
- Refocusing of resources available to address homelessness, with provision of long-term accommodation, including high-support residential services where required, and the expansion of floating support services identified as key priorities.
- The relatively weak performance in terms of implementation of the Homeless Preventative Strategy, with a need for better discharge systems and development of early intervention preventative actions.

Government accepted the 21 recommendations and declared its intention that the findings would serve as the basis for the subsequent development of new homeless strategy. When the *Independent Review* was published, it was also largely endorsed by key voluntary sector organisations. This meant that there was then unprecedented consensus across all key stakeholders about the way forward for national homeless policy. It seemed a relatively straightforward task to formalise this agreed path within the new strategy and to move along the road to what appeared to be a shared objective of ending long-term homelessness.

Ending homelessness: paradise found?

The first recommendation of the Review, that an end to long-term homelessness should serve as an overarching goal of new national homeless strategy, very much reflected the mood of the time that such an optimistic scenario was feasible. The concept of 'ending homelessness' was first placed on the Irish policy landscape in the Homeless Agency's action plan 2004-2006, *Making It Home*, with a commitment to end long-term homelessness by 2010. It was evident to us as independent evaluators that this was a clever tactic as it set a finite target to be met and also provoked much public debate about the feasibility of ending a problem which had been so visible on the streets of Ireland for many decades. When its adoption was recommended at national level in the Review in early 2006, it was clear that this was being perceived as an ever more practical goal.

The voluntary sector took up the baton later in 2006 with the launch of the MakeRoom campaign, based on a pledge to end homelessness (not just specifically long-term homelessness) by 2010. This campaign led to much discussion on just what was meant by ending homelessness and by setting such a challenge had an undoubted impact on raising overall awareness of the issue. The MakeRoom Alliance defined ending homelessness as "nobody sleeping rough, nobody living in emergency accommodation for longer than is an emergency and nobody becoming homeless because of a lack of appropriate services". At an event in December 2006, all major political parties in Ireland signed up to this pledge. Government commitment to such an end was further formalised with the release of the social partnership framework document, *Towards 2016*, which stated that: "the revised (homeless) strategies will have as an underlying objective the elimination of such homelessness by 2010".

Paradise lost?

With such commitment to ending homelessness across the board, building on an Independent Review with clear recommendations endorsed by all relevant parties, the future seemed incredibly bright. With statutory and voluntary sectors uniting around common goals and common actions, there was a wide degree of optimism that perhaps there really was potential for an end to homelessness in the State. The Review had also introduced a facilitating mechanism in this regard, with a National Homeless Consultative Committee created involving senior representatives from DoEHLG, HSE, local authorities, the Irish Council of Social Housing, the Homeless Agency and leading voluntary sector providers of homeless services around the country. For the first time all of the key stakeholders involved in addressing homelessness at both local and national level were sitting around a table in order to discuss and plan homeless policy.

Given this backdrop, why then, at the time of writing, has the new national homeless strategy yet to be published? In the three year period after the bulk of consultation and research for the independent review was undertaken, many local homeless fora have been reluctant to develop new action plans, and significant

momentum appears to be lost. With each passing day the prospect of ending long-term homelessness or the need to sleep rough by 2010 seems ever more remote, while a funding crisis for homeless services now appears to be upon us. At the same time, the messages originating from the voluntary sector are far more negative than was the case a couple of years ago and the consensus that has been built up now appears to be weakened considerably.

So just how was this idea of paradise, with everyone working together to end homelessness in Ireland, lost over such a relatively short period?

There are a number of clear contributory factors that have led to the present situation. Wider economic trends have undoubtedly placed a strain on government finances, and the almost exponential growth in funding for homelessness interventions throughout the last decade seems unlikely to be repeated. Personnel and structural changes within the two major funding and policy-making bodies, DoEHLG and HSE, have also had a significant impact, with the momentum and consensus built up between key contacts in these statutory bodies and voluntary service providers being lost amidst the changes. At the time there was almost a feeling that we were at the end of a journey where after years of work by key individuals in both sectors, an end to homelessness was a feasible goal. In effect there were clear policy 'champions' who were determined to find a way to achieve this end. There was a real commitment to change on both sides with a preparedness to address structural issues and refocus resources as required. The expertise still exists within the statutory and voluntary sectors, but it appears that changes in the financial and organisational constraints and difficulties in applying change management theory in practice have stalled progress.

The HSE is an excellent idea in theory, and its vision should sit very well with effectively addressing the health needs of people experiencing homelessness in the future. It should facilitate a consistent approach across all areas of the country and work towards a system where access to mainstream services is made available to people in such marginalised groups via primary care teams. However the organisation is still very much in a phase of development and appears beset by financial problems that dominate the media on almost a daily basis. The HSE, and before it the Health Boards, invested substantially in interventions to address the health needs of people experiencing homelessness around the country. However the Executive is now under significant pressure to provide short-term solutions to address major public concerns such as developing cancer services and adequately staffing Accident and Emergency wards. This makes it extremely difficult for social inclusion focused health-based interventions, where the cost savings are clear but generally medium and long-term in nature, to expand or even maintain their share of overall health funding. Hence there now appears to be a major financial barrier to securing the necessary commitments and resources to take the next step with regard to addressing homelessness in the state.

However there may also be a wider, almost cultural, issue that has served as the real underlying cause for such a breakdown in progress in addressing homelessness in Ireland. It has been noted how the National Homeless Consultative Committee brought statutory and voluntary sectors together to input into homeless policy development, but it would seem fair to say that the product from this process has not brought much satisfaction on either side. Although drafts of the new strategy have been circulated through this medium and comments fed back, ownership has very much remained in the hands of DoEHLG, and the voluntary sector has felt that it has exerted only limited influence in this regard. From the government's perspective, there may be a perception that the voluntary sector have adopted an overly negative approach in their engagement with this process, and that there is a reluctance to embrace the changes in the approach to homelessness that were recommended in the independent review. It is also natural that there is scepticism about the commitment of leading voluntary organisations to pursuing an end to homelessness, that there will exist a natural instinct to protect what is perceived in some quarters as the 'poverty industry'. Although there will always be a need for a core level of services to ensure that people are homeless for only as long as is an emergency, the realisation of this goal will require a major process of reprioritisation and change management. Yet it is immensely difficult for any organisation, be it private, public or voluntary, to seek to make any of its services obsolete, particularly when there still seems to be demand for such provision. There also appears disagreement on the level of resources required to address homelessness in Ireland, with statutory sources generally appearing to share a belief that funding is adequate if deployed in the correct areas moving forward, while voluntary sector providers push for additional investment.

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Given all these factors, there is now the prospect of a strategy that is too aspirational. This ignores a warning within the Independent Review that it is “important that any new strategy avoids aspirational objectives and actions that cannot be delivered due to a lack of resources.” It appears that the strategy will lack the detailed development of specific actions, designation of responsibility to specific parties and deadlines for implementation. It is also unclear as to how the implementation of the strategy will be funded moving forward. The Review called for the establishment of a “coordinated funding mechanism for the disbursement of capital and current accommodation and care related costs”, but it does not seem that specific commitments in this regard will be forthcoming, nor a timescale for implementation of such a mechanism. It is however essential that the strategy indicates how its various elements are to be funded and establishes joint DoEHLG and HSE capital and revenue streams for interventions to address homelessness.

In short, it seems to me that the new strategy will lack the focus on implementation that is essential if the shared goal to end homelessness is to remain valid. An impasse can almost be sensed in the current situation with regard to developing and implementing effective national homeless policy, with little flexibility evident in the positions of statutory and voluntary partners. Perhaps therefore it is time for more pragmatic and independent thinking in order to move things forward.

Paradise found

So has a significant opportunity been lost in the period since the Review was conducted? Certainly momentum has been lost by the delay in producing the strategy. Local homeless forums have become less active, homeless action plans have become outdated and the consensus built up between statutory and voluntary agencies that was articulated within the Review seems almost a distant memory. However there remain grounds for optimism, as the critical success factors that could make a scenario of ending homelessness feasible in the future are still very much in place, including:

- The relatively small scale and concentrated nature of the problem.
- Widespread agreement around the solutions that are necessary to address the problem.
- The fact that if resources are pooled and deployed more effectively they should be largely sufficient to provide such solutions.

So given these advantages, what is now the most appropriate course of action? A detailed implementation plan, on foot of the publication of the strategy, listing specific commitments and allocating funding to fully implement all of the recommendations of the Review would be the simplest and most effective way of moving things forward. However such a scenario is unlikely unless two fundamental issues can be addressed in its development that have hindered progress to address homelessness for many years:

- Effectively tackling homelessness requires a coordinated combination of accommodation related and health and care related interventions which are the responsibilities of two different government bodies with differing objectives, structures, systems and resources, making it immensely difficult for effective, integrated planning and delivery of appropriate responses.
- Voluntary sector providers of homeless services need to embrace a culture of change management within their organisations in order to facilitate the reprioritisation of resources and tackling of homelessness in a more coordinated and effective manner.

It would seem that government accepts the first of these points and even in 2000 recognised the need for integrated cross-department thinking in order to more effectively combat homelessness in Ireland. As acknowledged within this essay, there has been considerable progress since that time, particularly in developing coordinated local responses to homelessness around the country, but we remain at a point where the key barrier to further success remains the lack of an integrated response at government level.

Maybe, therefore, it is time to think outside the box a little, or at least have a look at the box which has been built not too far along the road. I feel it should be acknowledged that cross-agency responses such as Cross-Department Teams, the NHCC, Local Homeless Fora and Joint Agency Management Sub-Groups can only ever have limited impact unless they deal with the very complex steps of building shared responsibility and jointly

allocating resources. Perhaps the only way forward is to allocate Ministerial responsibility for dealing with homelessness in recognition of the fact that it requires cross-departmental funding and expertise. A precedent has been set in this regard with the creation of the Office of the Minister for Children. This took into account the fact that a coordinated approach to meeting the needs of the young in Ireland required a focus on health, education, childcare and early childhood development and social welfare. This combined a number of functions of the Department of Health and Children with the Irish Youth Justice Service of the Department of Justice, Equality and Law Reform and the Early Years Education Policy Unit of the Department of Education and Science. An overarching National Children's Strategy was developed and the Office was charged with its delivery.

A similar model would be worthy of consideration with regard to homelessness. The creation of a junior ministerial post and an attached Office of the Minister for Homelessness would immediately create the opportunity to move forward and address the remaining issues of coordination and integration, particularly in relation to funding. This Office could comprise appropriate staff allocated from DoEHLG and HSE, and perhaps also involve the Department of Social and Family Affairs, given the importance of welfare support in moving people out of homelessness. As part of the process, Cabinet would determine the overall budget for addressing homelessness, pooling together the money currently spent by the Department and the HSE in this regard into one single capital and one single revenue stream. The Office would be responsible for managing this funding and deploying it on full implementation of national homeless strategy, monitored by a set of agreed performance indicators.

The appointment of an appropriate senior person to take control of the office and attached budget would also be of critical importance. Given the need for joint-working rather than an approach led by either DoEHLG or HSE, the recruitment of an external expert from outside the civil service to head up such a team should be given serious consideration. This has been done successfully in the appointment of Professor Tom Keane as the National Cancer Control Director. Professor Keane was recruited due to his experience in transforming cancer care in Canada and has been assigned full control of HSE funding and resources for oncology services. A similar expert appointment with full budgetary control would provide real added value and focus to the activities of any new office charged with addressing homelessness.

This offers a relatively straightforward and pragmatic approach to addressing homelessness, assuming territorial issues around release of budgets and responsibilities could be resolved. Given that the various cross-agency structures employed to date have failed to secure an adequately integrated response, the only other option would seem to be transference of all responsibility for addressing homelessness to DoEHLG or HSE, with existing resources invested by the other body handed over to the one charged with this responsibility. However given that homelessness is so evidently about both health and housing, a shared function ministerial office would seem to be the most logical approach.

In my view the voluntary sector must also adopt a more constructive approach to development and delivery of national homeless policy. The endorsement by many of the key voluntary organisations of the Independent Review seemed a major step forward, as was the launch of the MakeRoom campaign. But ironically I feel the failing of the voluntary sector largely mirrors that of government. While clear aims have been set by voluntary organisations with regard to homelessness, they remain aspirational until there is a specific action plan in place to bring about their realisation. The voluntary sector is also faced with the challenge of gaining acceptance that it is actively working towards making its services obsolete. Why would a voluntary organisation providing homeless services want homelessness to end if it meant they would go out of business? Of course it is a more complex situation than that, as the vision of ending homelessness is more about preventing long-term homelessness and the need to sleep rough, so there will always be a need for some level of core services for those that find themselves without a home. But it also needs to be acknowledged that if progress is made towards the overall goal, existing services will not be required on the same scale. There is a valid argument, indeed one expounded within the Independent Review, that investment in homeless services should be phased down and funding refocused on long-term supported accommodation or tenancy support. However there seems to be no plan in place to reduce interventions to address homelessness over time and it would seem that all organisations intend to be just as active in 2011 as they are presently. The suggestion that services begin to look at a process of making themselves obsolete tends to be met with a response that more investment is needed not less, and reducing the level of a service cannot be contemplated until it is clear that the need no longer exists.

CHAPTER 4

I believe it is now time for the voluntary sector to be brave and get together to plot its own path towards ending homelessness. Key voluntary organisations should work in partnership to develop and publish an implementation plan highlighting how they would alter the services they offer if sufficient long-term accommodation was provided, making clear their strategy for change. This would demonstrate that there will always be a need for some outreach interventions and emergency accommodation services to put a roof over a person's head for a short period of time until a permanent housing solution is acquired. But it should also acknowledge that as blockages are removed by supply of long-term accommodation and care support where necessary, the need for these services will be reduced, and there will be scope for reducing overall levels of homeless service provision. By formally indicating how it intends to change, the voluntary sector would put pressure on government to deliver on its commitments, hopefully spurring it into action but at the very least calling its bluff, and making the prospect of ending homelessness seem like a real and achievable aim.

Both of these proposals would be highly challenging for the statutory and voluntary sector respectively. However it is clear that there does need to be a change in approach in order to make further progress with regard to homelessness in Ireland. If both these avenues were pursued, an overarching 'Covenant on Homelessness' could be developed. This would be signed up to by all relevant stakeholders, with an Office of the Minister for Homelessness delivering a programme of coordinated government action while, in response, the voluntary sector reprioritises its own activities according to changing needs. Such a 'Covenant' must not be based on rhetoric but focused strongly on implementation and shared responsibility for taking a set of agreed actions.

In Ireland the potential components are in place to generate one of the most significant achievements in modern Irish social history: an end to homelessness in the State. So much progress has been made in the last decade that it would be a terrible waste not to build on momentum and take the final steps towards this goal. There is absolutely no reason why the question everyone in the sector was asking three years ago – why should there be any homelessness in a modern prosperous Ireland? – is any less valid at this point. All that is really required is a proper constructive partnership to plan and deliver the interventions that both statutory and voluntary organisations broadly agree are necessary to bring about this scenario. Then, perhaps, it might be possible to reach the 'paradise' that all have agreed represents a feasible goal in the future.



CHAPTER 5

CHAPTER 5

HOMELESSNESS POLICY AND HOUSING OPTIONS IN THREE EUROPEAN COUNTRIES: IRELAND, SCOTLAND AND NORWAY

ISOBEL ANDERSON, EVELYN DYB AND JOSEPH FINNERTY

Abstract

This chapter examines recent developments in Irish homelessness policy and housing provision in a comparative context. The introduction situates the analysis in the broader context of comparative approaches to theorizing European welfare states, and explains the chapter's focus on Scotland and Norway as comparators for the Irish case.

The main body of the chapter compares homelessness across the three countries in relation to:

- (a) *issues in the definition and measurement of homelessness;*
- (b) *the profile of homeless people; and*
- (c) *changing homelessness policy and housing options for homeless people.*

The concluding section provides a comparative discussion which relates developments in homelessness policy and provision to the approaches to welfare in Ireland, Scotland and Norway, and reflects on the potential for wider comparisons across Europe.

Introduction: homelessness in an 'arc of prosperity'

As at 2008, Europe (geographically defined) comprises more than 30 nation states with diverse housing systems and varying approaches to defining, quantifying and resolving homelessness. The case for selecting countries for comparison with Ireland could be made on a range of grounds (random, similar, contrasting, etc). Our approach here is to begin with two of Ireland's geographical neighbours which are relatively similar in terms of size of national population and which appear to offer some commonality in contemporary approaches to tackling homelessness.

The selection of Scotland and Norway has particular resonance with recent political change in Scotland following the election of a minority Scottish National Party (SNP) administration as the government in Edinburgh. Scotland remains part of the United Kingdom but policy on housing and homelessness has been fully devolved to the Scottish Parliament since 1999 and the approach to tackling homelessness is increasingly distinct from that taken in England, Wales and Northern Ireland (Fitzpatrick 2004, Anderson 2007). In September 2007, the Scottish government published its overarching principles and priorities for its first programme in government, with the ambitious twin objectives of achieving stronger economic growth but also delivering a fairer distribution of the nation's wealth. The introduction to the SNP strategy states:

*We believe that Scotland can match the success of similar countries – Ireland to our west, Iceland to our north and Norway to our east, nations that sit at the top of world wealth league tables and form an **arc of prosperity** around our shores. Scotland has important lessons to learn from each of these neighbours in terms of competitiveness, investment and economic growth and it is this government’s job to offer a vision for Scotland that enables us to match, and we hope, exceed their achievements (Scottish Government 2007:9, authors’ emphasis).*

While it has not been possible to integrate Iceland into this analysis, we are able to offer some initial comparisons of the extent to which homelessness persists in the other three relatively prosperous northern European countries and assess the degree of commonality and convergence (or otherwise) in their approaches to tackling the issue.

Approaches to the comparative analysis of social policy, including housing and homelessness, have developed substantially since Esping-Andersen (1990) set out the thesis of three distinct path dependent models of welfare capitalism (universalistic, corporatist and liberal). Almost from its inception, however, the model presented problems for analysis of the European Union as the southern European countries (Greece, Spain, Italy and Portugal) were not well served by the analysis and of course the project was completed prior to the collapse of communism in Europe and the much later accession of post-communist states into the European Union. Moreover, housing was not a component of welfare in the Esping-Andersen analysis, and the extent to which housing can be interpreted as a ‘welfare’ service or benefit is similarly highly variable across Europe. Indeed, prior to Esping-Andersen’s analysis, Norwegian social scientist Ulf Torgersen (1987) characterised housing as “the wobbly pillar under the welfare state”, arguing that the status of housing within welfare was weaker in comparison to education, health and social security/pensions, which constitute the core of the welfare state.

Arts and Gelissen (2002) review subsequent critiques of, and alternatives to, Esping-Andersen’s thesis, concluding that real welfare states are usually hybrid cases, but that the welfare regime approach remains a valuable tool given the lack of alternative theoretical development for comparative social policy research. For housing, the essential question remains the extent to which provision is a dimension of welfare, as compared to a commodity to be traded in the market place. Housing tenure is often taken as an indicator of the commodification of housing and Table 1 provides data on key population and tenure statistics for the three countries. It can be seen that while the three countries have broadly similar populations, their tenure patterns are very different. Ireland and Norway have relatively higher home ownership, Scotland has relatively higher social rented housing and Norway has a particularly small social rented sector. The Norwegian private rented sector is nearly double the size of those of Ireland and Scotland.

Table 1: Indicative population and tenure statistics in Ireland, Norway and Scotland

	Ireland	Norway	Scotland
Population	4,314,634 2007	4,681,134 2007	5,117,000 2006
Housing/homelessness statistics			
Dwelling stock (2007/8)			
% Home ownership	75	80	65
% Private renting	10	16	10
% Social renting	11	1.5	25

Sources: Eurostat 2007 and Irish, Norwegian and Scottish national statistics.

Notes: An ‘other’ category amounts to 4% of tenure in Ireland. The total municipal housing stock in Norway amounts to 4% of tenure.

While post-1980 neo-liberalism has broadly resulted in the increasing marketisation of housing across most European countries, this chapter will demonstrate that, with respect to homelessness, the ongoing welfare role is not insubstantial. Doherty (2004) reflected on post-1990s comparative housing research, noting a common

theme of the role of state in the strategic development of housing policy, albeit reflecting the 'roll back' of the state and the continuing 'roll out' of neoliberalism (Peck & Tickell 2002). The resilience of state involvement in housing led to the conclusion that housing regimes of Europe, as embedded in national welfare states, demonstrated much continuity and the state remained a key player (Doherty 2004).

Within the original Esping-Andersen typology, Norway was one of the universalistic, social democratic welfare states characteristic of Scandinavia, while the UK (including Scotland) and Ireland were both classed as liberal, market driven welfare states. Anderson (2004) has however argued that the UK had more universalistic tendencies during the period of welfare expansion from 1945 to the mid-1970s. O'Sullivan (2004) however contends that Ireland is actually very difficult to classify within the Esping-Andersen scheme, and cites the 'social partnership' approach to policy development; historical state subsidies to home ownership and a continuing commitment to social rental housing as evidence of state-led housing policies (see also Finnerty 2002, O'Connell 2005).

Dyb (2007a) notes that state intervention in Norwegian housing policy has indeed been universalistic in nature, in line with the Scandinavian social democratic welfare model. The high proportion of home ownership was achieved with the support of general subsidies, notably interest rate subsidies post World War II which allowed the payment of mortgage interest to be withdrawn from taxation, and low interest rate loans submitted by the State Housing Bank. The Housing Bank was established in 1946 and emerged as the most significant post WWII housing policy tool. In essence, in the post-1945 period, the Norwegian social democratic government selected state supported home ownership in preference to state supported renting (Annaniassen, 2006). This was important in general housing supply, suggesting that the Norwegian housing model indeed matched Esping-Andersen's social democratic/universalistic welfare state regime. However, Dyb (2007a) also suggests that contemporary Norway can be characterised as displaying 'roll-back' of state intervention in housing policy combined with stronger engagement in homelessness policy, in line with arguments of Anderson (2004) for the United Kingdom and Sahlin (2004) for Sweden. From the 1980s, the objectives of Norwegian housing policy changed from an overall universalistic approach to a targeted policy aimed at groups with specific needs, and from the middle of the 1990s the remaining universalistic approach was effectively repealed (Annaniassen 2006).

Defining homelessness in the three countries

The profile of the homeless population in any country will first and foremost reflect its definition of homelessness, combined with the accuracy and frequency of quantifying homelessness. Outside of Scotland and the rest of the UK, definitions of homelessness tend to focus on rooflessness (Stephens & Fitzpatrick 2006) although FEANTSA has always argued for a wider definition (Edgar & Meert 2005).

Ireland

In Ireland, under Section 2 of the Housing Act 1988, a person is officially regarded as homeless if the housing department of their local authority judges that they have no accommodation that they can 'reasonably occupy', or are living in some form of emergency accommodation, and are judged to have insufficient resources to secure reasonable accommodation. This is an elastic definition which in principle might be interpreted to encompass a wide range of housing need. In practice, a narrow interpretation focuses on rough sleepers, those in emergency accommodation and transitional accommodation, and soon-to-be released prisoners without an address.

Norway

The definition of homelessness in Norway, by contrast, is not defined in legislation but set by a survey conducted in 1996 (Ulfrstad 1997) and repeated in 2003 and 2005 (Hansen et al. 2004, Hansen et al. 2006). Those counted as homeless in this survey are those in casual or temporary accommodation, people without an organised place of residence for the coming night, and those who are living temporarily with family, friends or acquaintances. Also included are people who are in prison or in an institution, and who are to be released or discharged within two months without an address. This rather narrow definition of homelessness effectively results in a homeless population very similar to 'vagrants', the majority of whom also have a serious addiction problem (Dyb 2007b). Those in precarious housing situations (e.g. moving between short-term arrangements) are not defined as homeless (Dyb 2007a).

Scotland

The current definition of homelessness for Scotland which is contained in Section 24 of the Housing (Scotland) Act 1987, as amended, defines homelessness for the purposes of the act as follows:

A person is homeless if he/she has no accommodation in the UK or elsewhere. A person is also homeless if he/she has accommodation but cannot reasonably occupy it, for example because of a threat of violence. A person is potentially homeless (threatened with homelessness) if it is likely that he/she will become homeless within two months. A person is intentionally homeless if he/she deliberately did or failed to do anything which led to the loss of accommodation which it was reasonable for him/her to continue to occupy. (Scottish Government 2008:18).

In practice, this definition is applied in such a way as to include a much wider range of housing need than in Norway or Ireland.

Measuring homelessness

As noted earlier, measured homelessness in different countries will reflect both varying definitions of homelessness and approaches to measurement.

Ireland

Every three years Irish local authorities conduct a national assessment of the extent of homelessness (stock rather than flow), as provided for in section 9 of the Housing Act 1988. The most recent data, from the 2005 count, showed a small reduction in the numbers of homeless households (from 2,468 in 2002 to 2,399 in 2005), but a large (46 percent) fall in the numbers of homeless persons (from 5,581 persons in 2002 to 3,031 persons in 2005), although this trend is disputed by some homeless providers. Most commentators do agree that roofless persons are predominantly male and single. Homelessness in Ireland is highly concentrated in the main cities, with Dublin accounting for over half of the recorded homeless population. The current extent of rough sleeping, according to official statistics, is quite low at around 150 persons in 2007. However, a significant factor impacting on demand for Irish homeless services in recent years has been the growth in homeless persons of Eastern European origin (Bergin & Lalor 2006). This growth is the result of three linked factors: a jobs-generating Irish economy, the eastern enlargement of the EU, and the application of a Habitual Residency Condition which bars anyone not resident in Ireland for the previous two years from claiming social welfare assistance.

Scotland

Official homelessness statistics for Scotland count the total flow of applicants who apply to local authorities for assistance under the legislative framework and thus enumerate a much higher level of households recorded as homeless across the year, than is the case for Ireland or Norway. A more accurate figure for international comparisons is therefore the stock of homeless households in temporary accommodation at the end of the accounting year (typically 31st March). Nevertheless, Scotland still emerges with a relatively higher level of homelessness, broadly reflecting its wider legal safety net. For example total applications to Scottish local authorities peaked at 60,500 in 2005-6, reflecting the widening of the safety net prior to full implementation of post-2000 changes described in detail below (Scottish Government 2008). Some levelling out may be in evidence with 59,500 applications recorded in 2006-7. Changing patterns mainly reflect increases in applications from single person households who have been the main beneficiaries of the post-2000 legislative changes. Similarly, households in temporary accommodation increased as new duties were implemented and again this may be levelling off. Overall, 60 percent of applicants were single persons, mainly men (Scottish Government 2008).

Looking at the narrower definition of 'people sleeping rough', Scottish Executive (2007) statistics indicated that in 2005-6, 7 percent of applicants reported sleeping rough the night before applying for assistance, which was down from 10 percent in 2002-3. The average number of people sleeping rough per month also fell from 440 in 2002-3 to 330 in 2005-6. As is the case in Ireland, those sleeping rough are predominantly single men aged 25-54. The Scottish Executive also funded counts of the number of people sleeping rough in specific reference weeks in spring and autumn during 2001-2003. For example, one count identified 328 people sleeping rough in one week in October 2003, compared to 130 formal applicants who said they had slept rough the night before

during the same period. This finding suggests that current published statistics may still be underestimating the extent of rough sleeping in Scotland (Scottish Executive 2007).

Norway

According to the last census there were 5500 homeless persons in Norway. The census was carried out during one specific week (week 48). 76 percent were men, mostly under 40 years of age and 70 percent were single. Three out of four were born in Norway. 8 percent, 440 persons, were either literally sleeping rough or stayed in overnight shelters with no place to stay at daytime. The largest group, 42 percent, were staying temporarily with friends or relatives, whereas 41 percent were in various types of treatment institutions, in prison or in homelessness shelters (Hansen et al. 2006).

The surveys do not capture all groups that are literally homeless and some groups are excluded for different reasons. The study *Roof For Everybody* carried out in winter 2006 in Oslo strongly suggests that the national survey underreported on rough sleeping. Excluded groups also included those characterised as being “homeless by political choice”¹. Other groups excluded from the last survey are refugees without a residence permit, who had left the refugee reception centre. It has been documented that this group is largely homeless by the definition applied in the surveys (Brekke & Søholt 2005). Another excluded group is trafficked women. The main argument against including these groups is that they have no legal rights to housing and services in Norway, and it is not useful for policy making to include them. This implies that the survey largely is a mapping of the number of people who are homeless and entitled to assistance from the authorities.

Homelessness policy and housing options

Ireland

As noted above, the Housing Act, 1988 set out a definition of homelessness for the first time in Irish legislation, and established a periodic count of the numbers of homeless persons under this definition. It also gave power to local authorities to intervene directly via cash payments (e.g. for emergency B&Bs) or direct provision (social housing, comprising the local authority and voluntary housing providers), or indirectly via cash assistance to voluntary bodies for providing emergency shelters, to assist homeless persons find accommodation. (The final housing option is via a rent supplement scheme, a demand-led housing benefit, with the Community Welfare Officer to whom the homeless person applies simply applying a means test to adjudicate on eligibility.)

However, the 1988 Act left unclarified the relations of local authorities with the other statutory provider, the Health Boards (now the Health Services Executive), and indeed with voluntary providers, and had given great discretion to local authorities in terms of who was to be counted as homeless and what services were to be provided to them. Under the Health Act 1953, the new Health Service Executive continues to have a broadly defined remit to cater to the needs of homeless persons.

Taken as the main response to homelessness, the 1988 Act did little to address issues of prevention and of meeting non-accommodation support needs. Additionally, the Act made little difference to the social housing allocations policy of many local authorities, though the lack of data makes monitoring difficult (Bergin et al. 2005, Finnerty & O’Connell 2006). A more ambitious policy response to adult homelessness was proposed in the policy documents *Homelessness – An Integrated Strategy HAIS* (2000) and the *Homeless Preventative Strategy* (2002). The HAIS involved an emphasis on partnership working between local authorities, Health Boards and voluntary agencies, via local action plans and local homeless fora². Substantially increased funding was committed under HAIS, with local authorities responsible for funding ‘bed nights’ in shelters and capital expenditures, and Health Boards for in-house care and health needs. The HAIS also signalled a shift in focus towards moving people out of shelters, with an increased stress on transitional accommodation, with increased attention to the health, training and life-skills issues that homeless people may face, and to the variety of supports that may be required in moving on from emergency accommodation³.

Both strategies were the subject of an official independent review (Fitzpatrick Associates 2006) whose findings the government has broadly committed to endorse. It found that HAIS in particular had been successful in terms of generating increased funding for the sector, in promoting joint working between the statutory and voluntary

1 Minister of municipalities and regions in the former government.

3 The Homeless Preventative Strategy focused on discharge policies for those leaving state care.

2 In the Dublin area, the Homeless Agency co-ordinates the planning and implementation of homelessness policy.

sectors, and in reducing rough sleeping. One of the more detailed recommendations is that resources previously focused on the provision of emergency accommodation should be redeployed to the provision of long-term accommodation. It is also recommended that the focus should be on the provision of long-term accommodation rather than on transitional accommodation (usually provided by voluntary bodies, with capital costs funded by the DoEHLG). This recommendation embodies the 'housing first' emphasis now widely espoused in relevant policy documents (see e.g. the strategic policy statement in DoEHLG 2007).

In a significant departure from HAIS, the use of the private rented sector proposed by Fitzpatrick Associates parallels the recent DoEHLG (2007) emphasis on the new Rental Accommodation Scheme⁴ as a long-term housing option for homeless persons.

The main recommendation of Fitzpatrick Associates (2006) was that:

"The Integrated and Preventative Homeless Strategies should be amalgamated and revised. The resultant revised strategy should have an overarching goal to eliminate long-term homelessness in Ireland by a defined date in the future, and include clearly defined objectives, actions, projected outcomes, timescales for delivery and an appropriate monitoring mechanism to track progress."

This successor document, in circulation in draft form in 2008 was called *The Way Home*. Its difficult gestation period was widely interpreted to stem from the continuing disagreements amongst the two statutory providers about their roles and responsibilities in this area. Indeed, in the context of an economic slowdown and an increasing budget deficit, the likely cost of fully implementing a 'housing first' strategy may lessen official enthusiasm for this policy stance. The government endorsement of this recommendation may well have been based on the sanguine view by Fitzpatrick Associates (2006) that this would effectively be a cost-neutral strategy, involving the switching of existing expenditure from emergency and transitional to long-term accommodation responses

Scotland

The legal and policy framework for homelessness which existed prior to devolution had been in place across England and Scotland since 1977. The framework placed a legal duty on local housing authorities to take action where individuals or households presented themselves as homeless or threatened with homelessness. The legislation did not, however, treat all homeless households equally. From its inception, local housing authorities were required to apply four 'tests' to those in housing crisis:

1. *Is the household 'homeless' as defined in the legislation?*
2. *Is at least one member of the household in 'priority need' of accommodation, defined as:*
 - a. *Household with children of school age or an expectant mother?*
 - b. *Households 'vulnerable' due to old age, health, disability or other 'special reason'?*
 - c. *Household homeless because of an emergency such as a fire or flood?*
3. *Has the household become homeless 'intentionally' (by deliberate act or omission which led to homelessness)?*
4. *Does the household have a 'connection' with the local authority to which they have presented (for example through residence or employment)? If the household does not have such a connection with the local authority to which it applies, it may be referred to another area for long-term housing, although temporary accommodation would normally be provided pending such a decision.*

By and large, over a 20 year period, households who applied for assistance and met these tests were rehoused in secure council or housing association tenancies. The legislation worked much less well for single people and couples without children, who were largely excluded from the benefits of the legislation. This led to the introduction of special initiatives to tackle rough sleeping during the 1990s. Scotland had a policy target that by the end of 2003 'no one should need to sleep rough' and, to an extent, real reductions in rough sleeping were achieved (Anderson 2007a).

⁴ The RAS represents a development of the rent supplement scheme described earlier. Effectively, the local authority would let the accommodation from participating private landlords and sub-let to qualifying households.

During the period 1999-2007 a Labour/Liberal Democrat coalition government in the newly created Scottish Parliament undertook a major review of this homelessness legislation. The review was conducted by a specially constituted Homelessness Task Force (HTF) which published an interim report in 2000 and its final report and action plan in 2002 (Homelessness Task Force 2000, 2002). As well as representing a strategic framework for a new approach to homelessness in Scotland, the Task Force reports made recommendations for legislative change which were subsequently enacted in the Housing (Scotland) Act 2001 and the Homelessness, etc. (Scotland) Act 2003.

The Housing (Scotland) Act 2001 required local authorities to produce comprehensive strategies to assess the level of homelessness in their areas and to provide temporary accommodation for all homeless households (typically for 28 days) until a full decision is reached on their application (Scottish Executive 2005: 55). Perhaps the most significant recommendation for legislative change was the phasing out of the longstanding differential treatment of households according to 'priority' or 'non-priority' need status by the target date of 2012. The HTF also recommended dispensing with the other two tests ('local connection' and 'intentionality'). On full implementation, the four tests of the 1977 legislation would be reduced to one – is the household homeless? The Homelessness etc (Scotland) Act 2003 (Office of Public Sector Information, 2003) further extended the existing definition of priority need and set out the framework for achieving the ultimate aim of ensuring that by 2012, everyone assessed as being unintentionally homeless in Scotland would be entitled to permanent accommodation.

Anderson (2007b) has provided some assessment of the first five years of progress with this new framework, although the scope for analysis was limited by the lack of transparent and rigorous monitoring of progress at the national level. From available evidence however, Anderson expressed concern that implementation was not yet matching the high expectations of what was widely recognised as a very progressive review and a significantly changed legislative framework. For example while local authorities were given flexibility in meeting their expanded duty to abolish the priority/non-priority distinction, this meant at least a temporary lack of clarity and arguably fairness in terms of who should be brought within the safety net sooner rather than later.

The newly elected SNP government publicly confirmed in 2007 its commitment to the 2012 homelessness target, with a switch of emphasis to service delivery (Scottish Government 2007, Chartered Institute of Housing 2007). The new government launched a major consultation on housing policy in 2007/8 with the publication of its Firm Foundations discussion paper (Scottish Government 2007b). While this document heralded some key policy developments, notably an overall increase in housing construction and support for a return to new council house building, it had little new to say on homelessness, given the extent of the previous review and sustained consensus on the approach. However, the Firm Foundations paper did raise the question of whether greater use could be made of the privately rented sector in meeting the 2012 target, marking an important departure from the long standing practice of valuing the security of social rented housing as the main solution to homelessness.

Norway

In common with Ireland and Scotland, Dyb (2007a) notes that homelessness has been uncharacteristically high on the Norwegian policy agenda in the post-2000 period. The first systematic national initiative to curb homelessness, Project Homeless, was launched in White Paper No. 50 (1998-99). Project Homeless was primarily a trial scheme to develop models and methods to curb homelessness and to build competence about homeless people needs. The prime target group was homeless persons with drug addiction and double diagnoses addiction/mental health problems. The evaluation of the project drew some important lessons, which became important in developing a homeless policy (Dyb 2005):

- The project created acceptance for right to homeless people with substance misuse or double diagnoses abuse/mental health problems, often seen as the 'undeserving' people, to have access to housing and services.
- Project Homeless became a housing project. The 'housing first' approach, which is the current homelessness policy, developed throughout the project.
- Building competence was important and necessary.
- The results from the project seemed to be implemented and grounded in management and professional departments in the municipalities.
- There had been too little room in the project overall for other groups than the primary one (persons with substance abuse and double diagnoses).

Building on this evaluation of Project Homeless, the Norwegian government developed an ongoing strategy against homelessness for the 2005-2007 period, *The Pathway to a Permanent Home*. The new strategy built on Project Homeless, and on a broad vision of good, safe, housing for all, with the specific goals and targets set out in Table 2.

Table 2: Norwegian Homelessness Strategy (2005-2007), goals and targets

General Goals	Targets
Help prevent people from becoming homeless	<p>Number of eviction petitions to be reduced by 50% and evictions by 30%</p> <p>No one shall have to seek temporary housing upon release from prison</p> <p>No one shall have to seek temporary housing after release from a treatment institution</p>
Contribute to good quality overnight shelters	No one shall be offered overnight shelter that does not meet agreed quality standards
Help ensure homeless people rapid offers of housing	No one shall stay more than three months in temporary housing.

Source: Sveri 2004:73.

Edgar (2006) notes the overall programme aims at including the prevention of homelessness for people threatened with eviction and for people leaving prison or institutions, also improvement in the quality of shelters, and a reduction in reliance on temporary accommodation and time spent in temporary accommodation. Edgar notes that the national housing policy was being delivered by 431 municipalities in Norway (a much higher number than in Scotland or Ireland). Drawing on monitoring information provided by the Norwegian State Housing Bank and a survey of homelessness, Edgar concluded that there had been significant positive achievements in the early phase of the strategy. Unfortunately, the detailed data are not reproduced in Edgar's 2006 paper. Nonetheless, he commends the role of the Housing Bank in policy implementation (the Scottish equivalent, Communities Scotland, was abolished by the SNP government in 2008, and there is no equivalent body in Ireland).

The responsibility for homelessness at government level in Norway is divided between housing and social security authorities. Again, as with Ireland and Scotland, Dyb notes that the strategy was developed by national government with responsibility for implementation directed to local authorities, and that the Norwegian approach included funding for a variety of homelessness projects to support local implementation of state policy. However, Dyb (2007a) argues that social housing in Norway remains inadequate to meet either need or demand, which is also strongly emphasised in a recent report from the Office of Audit General of Norway (Riksrevisjonen 2007). Some local authorities have responded by renting from the private market and sub-letting to their clients, with similarities to Ireland's Rental Accommodation Scheme, where long social housing waiting lists also feature.

The tools with which the Norwegian government is steering the national homelessness policy include funding specific projects which are coherent with the overall targets and objectives of homelessness policy. Local actors, in particular local authorities, but also NGOs, other organisations and private enterprises are encouraged to apply for funding for individual projects. A very important part of the national homelessness strategy is networking and formation of formal collaboration agreement both vertically and horizontally, between private and public actors and among public actors. Such approaches are also evident in the implementation of local homelessness strategies in Scotland and in Ireland. A substantial part of Norwegian government funding is directed towards the formation of networks and collaboration agreements. The use of forums to improve practice do have comparable equivalents in Scotland and Ireland.

Conclusions: towards a comparative understanding of homelessness

Despite differing historical welfare paths, and differing contemporary tenure structures, some key aspects of convergence on homelessness policy can be identified across Ireland, Norway and Scotland. A key feature of approaches to homelessness in all three countries is not just the sustained involvement of the central state, but also the crucial role of the local state in the implementation of nationally set policy and strategy. All three countries have introduced national strategies with broad goals of integrated service provision, supported by partnership working. All at least recognised the need for support services as well as housing provision and all made use of incentive funding to encourage local delivery of the national strategy. Broadly, all now have a goal of providing at least temporary/emergency accommodation for all citizens or ending the most extreme experience of street homelessness.

Scotland is characterised by a greater willingness to resort to legislation while Ireland and Norway have relied more on financial incentives to encourage local delivery (which were also adopted in Scotland). Because of its detailed legal framework, Scotland could be characterised as the country with the most comprehensive approach. However, that conclusion should perhaps be interpreted in the light of Scotland having the highest overall level of homelessness among the three countries compared. Stephens and Fitzpatrick (2006) concluded that the UK (including Scotland) was still unusual in having a legislative basis for legally enforceable rights for homeless households. The legislative basis also applied in Germany, but only for temporary accommodation (not settled/secure accommodation as in the UK). In Sweden, Poland and Hungary limited rights for emergency accommodation for some homeless groups were identifiable and social welfare legislation assisted homeless people in other countries. France introduced a legally enforceable right to housing in 2007 (Loison 2007).

In terms of housing outcomes for formerly homeless people, commentators have characterised the social rented sectors in all three countries as residualised, notwithstanding the very different scale of the sector across the three. Stephens et al. (2003) also demonstrated the diversity in the conception of 'social rented housing' across six EU countries, particularly in terms of the client groups who live in the tenure. Ireland and Scotland (and to a lesser extent Norway) are exploring greater use of the privately rented sector to assist in resolving homelessness. Cost is obviously a key factor and, importantly for Scotland, Housing Benefit and the new Local Housing Allowance for private tenancies are reserved matters to London/the UK parliament, over which the Scottish Government has no control.

Ireland is to be commended for having commissioned and published independent reviews of the progress of its strategies and the Norwegian strategy is currently being evaluated. It is to be hoped that Scotland will do the same, as was the case for the earlier Rough Sleeping Initiatives (Anderson, 2007a). That said, only Scotland (along with the rest of the UK) routinely collects and publishes a comprehensive set of homelessness statistics over the long-term, which certainly contribute to monitoring the impact of change.

The three country analysis of Ireland, Scotland and Norway demonstrates considerable convergence in approaches to tackling homelessness despite continuing divergence in wider housing market structures, notably in the balance of tenure. All three welfare states have exhibited rollout of neoliberalism to some degree – if from different starting points and at different paces. All three housing systems give precedence to the market but certainly not to the extent of withdrawing or failing to provide a basic safety net for those facing a homelessness crisis. Some characteristics of 'path dependency' can also be identified with Norway emerging as still the 'best housed' nation; Ireland's housing and welfare policy still reflecting its agrarian past and later economic development; and Scotland's overall economy and housing/homelessness landscape reflecting its long-term relatively poorer status than its much larger immediate neighbour, England. Looking forward, all three countries clearly have a sound basis for progressive policies to end the most extreme manifestations of homelessness and integrate wider strategies to move towards the provision of reasonable housing for the whole population. This has been achieved during a decade of economic growth and relative prosperity. A key question for the next decade may be whether commitment to ending homelessness can be sustained in a much more uncertain national and international economic climate.

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Evidencing homelessness

Chapter 6:

Can we agree the number of people who are homeless (and does it really matter)?

Nathan O'Connor

Chapter 7:

Pathways into, through and out of homelessness

Jane Pillinger

CHAPTER 6

CAN WE AGREE THE NUMBER OF PEOPLE WHO ARE HOMELESS (AND DOES IT REALLY MATTER)?

NATHAN O'CONNOR

Introduction

How many people are currently homeless in Ireland? This is an important question that is both powerful and insistent. It is powerful because simply asking the question demands recognition that there are people who are experiencing homelessness in Ireland at this moment. It is insistent because it implies that once we know the answer, we will be in a situation where Ireland (the State and its people) will be obliged to recognise this inequality and to do something about it. This is in spite of the fact that different people have a different understanding of what this implies and whether it means responding simply to visible rough sleeping or includes responding to the wider range of people living in various forms of temporary accommodation due to the lack of access to appropriate housing.

Although the question is important, two significant difficulties arise when trying to address it. Firstly, the question is deceptively simple. There is nothing close to universal agreement about how to define homelessness. As a result, it is highly likely that there will never be universal agreement about how many people are currently homeless. Secondly, the issue of homelessness is highly emotive. It is difficult to discuss accurate measurement techniques without being accused of callousness towards the people who are currently living the reality of homelessness. At the same time, there can be undue haste in presenting figures to the public (and triggering an emotive response) if it satisfies an organisation's agenda to do so.

Often, figures on homelessness presented to the general public via the media present only a partial picture. Corrigan et al (2002) noted that for Ireland the 'absence of reliable data on the homeless population represents one of the most significant data gaps in our knowledge and understanding of poverty'. However, this does not imply that it is necessary for us to offer a simple answer to the question of how many people experience homelessness. In contrast, I argue that we can't easily reach agreement by way of one overall figure on how many people are homeless. Instead I suggest that we take a closer and more scientific look at what experiences of homelessness we can measure and seek agreement on how to react to available knowledge.

This essay does not set out to comprehensively cover the academic debate on the difficulties of measuring homelessness (see, for example, Williams 2005). Instead, I outline some of the reasons why disagreement has occurred about the number of people who are homeless in Ireland. The goal of this essay is to move beyond these differences without undermining the valid reasons for them and to outline ways of agreeing how homelessness can be measured and understood.

We can't agree

There is frequent disagreement between government, opposition parties, non-government organisations (NGOs), the media and others about the current extent of homelessness. Even within any given group, there can be disagreement about the definition and overall extent of homelessness.

Perhaps the strongest example of this disagreement is the dichotomy between statutory and voluntary organisations' perspectives on homelessness. Although I will characterise these views as the 'statutory' and 'voluntary' perspectives respectively, this should not oversimplify the range of opinion to be found on both sides as well as considerable areas of agreement between them. Both sides agree that people experiencing homelessness are not a homogenous group and that there is a range of causes of homelessness. Nevertheless, there are fundamental differences between these two broad points of view.

The main attribute of the voluntary perspective on measuring homelessness is the desire to be as inclusive as possible, in order to ensure that no person in need is left out of any enumeration of homelessness. Voluntary bodies are often advocates for those who, for one reason or another, are either excluded from the criteria of entitlement for state assistance to attain certain basic means of survival or else are unable to advocate for themselves to gain their entitlements. This advocacy role is important, but it is also the root of discontent with official statistics.

The voluntary perspective can be more flexible with regard to its definition of homelessness. Charitable bodies are often the last refuge of those who have fallen through other social safety nets. As such, they tend to respond to presenting need on a humanitarian basis first, rather than question someone's official status or eligibility. At the same time, voluntary homeless services may lack the administrative capacity to ensure that accurate records of service use are maintained.

Another, more sceptical point of view argues that voluntary service providers need to be able to point to higher levels of homelessness in order to justify their existence and to lobby for funding (whether from the State or from private donors). Although it is plausible that funding may decrease as homelessness decreases, a possible incentive to 'talk up' homelessness should not be allowed to obscure the fact that NGOs will encounter people in need who are invisible under current statutory definitions of homelessness.

The main attribute of the statutory side's perspective is to provide a sufficiently clear definition of homelessness in order to be able to draw clear boundaries and make distinctions around who is entitled to what share of state-provided goods and services. In contrast to the voluntary perspective, this is an exclusive definition of homelessness, as it requires tighter classification in order to protect scarce public resources from potential abuse. For example, the criteria for accessing state-provided housing must try to prevent people simply declaring themselves homeless in order to improve their qualifying criteria on the housing waiting list to gain a greater entitlement and speedier response.

The Housing Act 1988 provides the basic definition of homelessness, which is further elaborated by the rules and regulations developed by each housing authority in operating homeless priority on its housing waiting list.

The 1988 Act (Section 2) defines a homeless person as follows:

A person shall be regarded by a housing authority as being homeless for the purposes of this 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 reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or
- (b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources.

While the statutory definition is theoretically broad, it is also too general to be easily made operational by local housing authorities. As a result, the authorities enforce rules and stipulations to narrow the range of eligibility in an attempt to ensure that only those persons considered to be genuinely in need will be given a priority response. Thus, even if an authority develops a sophisticated set of rules to take account of the different causes and manifestations of homelessness, it is still ultimately an exclusive definition of homelessness because it must by necessity draw clear boundaries between eligibility and non-eligibility for state assistance.

Official processes and assessments of need are themselves a cause of difficulty when it comes to measuring homelessness. This is because routine administrative tasks that are essential to demonstrating and assessing

need (such as completing forms, attending appointments and staying in touch with officials) can be beyond the capacity of people experiencing homelessness who may have other, unmet support needs related to mental health, learning difficulty or addiction. As such, people who experience homelessness may not always have the other supports they require to complete these processes and may consequently remain outside of the official statistics on homelessness.

In summary, and allowing for the variety of perspectives on both sides, voluntary bodies have a valid concern to recognise and include everyone who presents with an unmet need relating to housing and social inclusion. On the other hand, statutory bodies are usually given the task of administering scarce resources and are required to lay down clear criteria for who can access these resources. As a result of this dichotomy, it is clear that an inclusive definition of homelessness will almost certainly count in more people than an exclusive one. Because of this, I argue that it is impossible to seek a single, agreed figure on the number of people who are homeless without damaging the integrity of one or both of these equally valid positions.

What we could do

If it is true that there are fundamental reasons why we cannot agree on how to define homelessness, then logically we should question what we are trying to achieve through the measurement of the number of people who are homeless. At least, we should stop seeking a 'perfect' method and expecting everyone to agree to its findings. In addition, the search for a compromise method of measuring homelessness should be abandoned as inevitably unsatisfactory if it requires strongly held convictions to be compromised in relation to the definition of homelessness and the conception of who is in need. It should not be necessary for anyone's values to be compromised in order to agree what a given method actually measures.

I suggest that the central idea to be accepted on all sides is that a scientific approach to homelessness does not entail developing a perfect method. Rather, a scientific attitude demands that we acknowledge that different definitions of homelessness, and different methods for measuring it, will result in different findings.

This is not an argument for relativism, in the sense of all measurements being equally legitimate. Clearly, there are more or less accurate methods. The call for a more scientific approach encourages continual improvement in how the experience of homelessness is recorded and measured, but it also requires us to acknowledge the limits of any one method. Equally, the claim that measuring homelessness is complex and imperfect is not an argument against doing any measurement at all. On the contrary, anyone who is sincere about ending homelessness needs to adopt a scientific approach towards its measurement.

A scientific approach entails a transparent process of using different methods to measure different aspects of homelessness. The process must be transparent to make it clear what is being measured and what can reasonably be inferred from the findings.

What our current measurements actually measure

The Homeless Agency Partnership has developed various methods to answer the question of how many people are currently homeless in Dublin. The development of these methods has involved both statutory and voluntary partners. Two examples are given below to illustrate both how transparency is achieved in practice and also how the findings of each method are understood.

The first example is a revised method for conducting street counts of people sleeping rough¹. The importance of these street counts is to monitor part of the vision of the Homeless Agency Partnership, which is to eliminate the need for anyone to sleep rough by 2010. Street counts have been carried out in the past, but there was not a fully agreed approach to how they should be undertaken and disputes had arisen around some count findings. As the issue of people sleeping on the street is both emotive and politically charged, there was a need to establish an agreed method so that data could be gathered to monitor progress towards the achievement of the vision.

¹ To date this method was used in November 2007 and April 2008.

² Department of Communities and Local Government.
See <http://www.communities.gov.uk/archived/publications/housing/guidance>

In advance of the count, information was sought from the general public as well as from services working with rough sleepers. Maps were prepared in advance covering the entire city centre as well as every suburb where there was any indication that people might be sleeping rough. The one-night street counts involved teams of counters walking down every street and alley in the city centre, as well as driving through suburban areas, and taking note of anyone who was or might be sleeping rough.

Based on a method developed in the UK², the count form sought to ensure clarity by asking counters to use the principal form (A) to record people actually bedded down and to record any possible rough sleepers on a secondary form (B). The use of two forms allowed the maximum information to be recorded without blurring the number of people observed to be definitely bedded down. After the count was concluded, a voluntary representative and a statutory representative were invited to agree the number of people from the A forms that would be counted as well as to discuss including some cases from the B forms. Both sides were given a veto, so that there would be unanimity about the final count figure. Also, both sides were clear that the final count figure represented the minimum, definite number of people observed to be sleeping rough on the streets on the night in question.

This method accepts that it is not possible to count everyone sleeping on the streets because some people are too well hidden, or are sleeping inside locked private property or in some places that are too dangerous to access by the count team. Both sides might continue to disagree about how many people might be rough sleeping in hidden locations or even what constitutes rough sleeping; but at the same time, both sides can agree that the count was a fair representation of the number of people who were met according to the definition adopted for the street count. This allows both sides to seek action on the basis of the number that was counted, while not having to compromise on their respective perspectives on defining homelessness.

The second example is the Homeless Agency's Counted In survey. This method is a development that stemmed from the national Housing Needs Assessment established by the Housing Act 1988, whereby housing authorities must conduct a regular assessment of the housing need in their area. The Department of the Environment, Heritage and Local Government (DoEHLG) issues circulars describing what information from the assessment process is to be submitted for inclusion in national statistics.

In practice, the Housing Needs Assessment has equated to a review of social housing waiting lists in order to ensure that the information held in them is up-to-date. The assessment specifically includes a count of everyone who is homeless in each area. However, the method used in the past was simply to validate the names of those who had been given homeless priority on the housing waiting lists. The problem with the validation of the housing lists as a count of homelessness was that the process necessarily excluded people who, for a variety of reasons, may never have been included in the list, despite meeting the eligibility criteria. The enumeration of homelessness also excluded those who might be homeless but who are ineligible for social housing.

The *Counted In* method responded to these concerns by conducting a week-long survey of everyone who was currently using homeless services. In 1999, 2002 and 2005, the *Counted In* survey was carried out in parallel to the Housing Needs Assessment homeless survey. In 2008, the Homeless Agency and the four Dublin local authorities agreed an improvement in the process, whereby the Homeless Agency carried out one survey to supply the information for both the Housing Needs Assessment and the Counted In report.

What Counted In provides is a fairly complete census of everyone using homeless services during the week of the survey. It does not claim to count everyone who is homeless, as it is always possible that someone might be homeless but could choose not to engage with any homeless services. However, the survey was carried out in nearly every homeless service in Dublin, and project workers were very helpful in ensuring that everyone was included. As such, the survey provides a robust minimum figure for the number of people using homeless services during the week of the survey. As with the rough sleeper count, there is no need for different sides to change their beliefs about what constitutes homelessness. The Counted In survey cannot claim to be the final word in assessing the number of people who are currently homeless, however it provides a robust measurement that can be used for the planning and delivery of homeless services and housing solutions.

Structuring the assessment of homelessness

When it comes to combining different measurements, it is not sufficient to merely blend them together. Instead, there must be a coherent framework that shows how different measurements each contribute to an overall understanding of homelessness. In turn, it is important that measurements of homelessness are compatible with other measurements of social exclusion as well as general social measurements, such as the Census or population health statistics.

The European Typology of Homelessness and Housing Exclusion (ETHOS) can be used as a framework to understand how different measurements of homelessness contribute to a better overall understanding of the phenomenon. In the same way, ETHOS shows how homelessness is related to wider issues, such as insecure and inadequate housing.

Essentially, what ETHOS does is put homelessness into a bigger picture. For example, starting from how many households live in Dublin and how many housing units there are, we can begin to examine the dynamics of the housing market to see how different people are housed and what factors are preventing some people from accessing adequate housing.

As Figure 1 illustrates, the large proportion of the population of Dublin has access to adequate and secure housing of one sort or another. A small proportion lives in inadequate or insecure housing. A very small proportion of the overall population lives in some form of houselessness or rooflessness. Further research is needed to determine how many people are living in each broad category, as well as in the more detailed sub-groups under each heading.

Figure 1. The housing status of the whole population



The area of most concern for homeless services is the interface between inadequate/insecure housing and houselessness/rooflessness (illustrated by a solid black line in the diagram). Most people who come into homelessness every year do so from a situation of inadequate and or insecure housing. Initiatives to tackle housing need and to minimise the number of people living in these circumstances are obviously crucial to preventing homelessness from occurring.

As Figure 2 shows, ETHOS provides detail about the different categories of homelessness and also includes various categories of people potentially at risk of homelessness. By gathering data under each of the categories listed, through examining existing administrative data and possibly undertaking new research, it is possible to generate a more complete understanding of both the current situation in relation to housing need and homelessness, as well as to understand some of the dynamics of homelessness.

For example, it is believed that a number of people are caught in a cycle between homelessness and prison and/or homelessness and hospital (especially psychiatric units). By developing measurements of the number of people in different situations who are at risk of homelessness, it is easier to put in place effective preventative measures to ensure that people do not become homeless. The measurements also make it much easier to estimate the resources that will be needed in each area.

Figure 2. European Typology of Homelessness and Housing Exclusion (ETHOS)³

Conceptual Category	Operational Category		Living Situation	
Roofless	1	People living rough	1.1	Public space or external space
	2	People in emergency accommodation	2.1	Night shelter
Houseless	3	People in accommodation for the homeless	3.1	Homeless hostel
			3.2	Temporary accommodation
			3.3	Transitional supported accommodation
	4	People in Women's Shelter	4.1	Women's shelter accommodation
	5	People in accommodation for immigrants	5.1	Temporary accommodation/reception centres
	6	People due to be released from institutions	5.2	Migrant workers accommodation
			6.1	Penal institutions
			6.2	Medical institutions
	7	People receiving longer-term support (due to homelessness)	6.3	Children's institutions/homes
			7.1	Residential care for older homeless people
8	People living in insecure accommodation	7.2	Supported accommodation for formerly homeless people	
		8.1	Temporarily with family/friends	
Insecure	9	People living under threat of eviction	8.2	No legal (sub)tenancy
			8.3	Illegal occupation of land
			9.1	Legal orders enforced (rented)
	10	People living under threat of violence	9.2	Re-possession orders (owned)
			10.1	Police recorded incidents
Inadequate	11	People living in temporary /non-conventional structures	11.1	Mobile homes
			11.2	Non-conventional building
			11.3	Temporary structure
	12	People living in unfit housing	12.1	Occupied dwellings unfit for habitation
			13	People living in extreme overcrowding
13.1	Highest national norm of overcrowding			

Conclusion

Over time, different measurements based on different definitions of homelessness have been cited by different organisations for different purposes. This has led to persistent disagreement about measuring homelessness. However, it is possible to move beyond this situation and to agree that a variety of measurements can contribute to a better overall understanding of homelessness. Continual improvement of measurement is both possible and desirable, but at the same time there is unlikely to be agreement on a single, ideal method. Instead, the challenge to all stakeholders in the planning and delivery of responses to homelessness is to adopt a more scientific attitude to its definition and measurement. Frameworks like the European Typology of Homelessness and Housing Exclusion can provide a way of structuring and explaining a more nuanced approach to understanding homelessness.

Part of the challenge of adopting a more scientific approach to measuring homelessness is communicating a higher level of detail and complexity to key stakeholders, such as politicians and the general public. Demands from these stakeholders can often return to the emotive and politically sensitive question of 'how many people are currently homeless?' (Or even, how many people are 'really' homeless?). This can put pressure on public servants to produce a definitive figure or else put pressure on NGOs to provide evidence to back up their calls for public action. However, it is misleading and unhelpful to seek a simple answer to what is inevitably a complex question.

If voluntary and statutory bodies working in the area of homelessness agree to use transparent methods that allow observers to see exactly what is being measured and how the findings were generated, does it matter if they cannot agree on the definition of what constitutes homelessness?

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³ ETHOS 2007. See <http://www.feantsa.org>

CHAPTER 7

PATHWAYS INTO, THROUGH AND OUT OF HOMELESSNESS

JANE PILLINGER

Introduction

This chapter presents a conceptual framework for the pathways approach to homelessness, by taking a life course approach. Research on homeless pathways is relatively new to Ireland. Particular knowledge gaps exist in the long-term tracking of individuals as they move through services and the identification of barriers and successful interventions. Homeless pathways research carried out for Focus Ireland in 2007 aimed to address this knowledge gap by providing an analysis of the complexity and diversity of homeless people's pathways into, through and out of homelessness. Using a life course approach and based on in-depth interviews with 22 Focus Ireland clients (Pillinger 2007) the research argues for measures to address the causes and risks of homelessness at different stages of people's life cycle.

Locating homelessness in the social, structural and economic contexts of people's lives (Fitzpatrick & Klinker 2000), has a number of implications for policy and service provision. Although there is now a greater emphasis on prevention and early intervention in policy¹, this has been difficult to implement because of the continued emphasis on crisis interventions and a limited policy emphasis on people living in precarious housing situations or who are at risk of becoming homeless. Understanding the complex chain of risks that can lead to homelessness (Pillinger 2005) can result in the development of a better understanding of how a lifecycle approach to prevention can be applied to homelessness (Graham & Power 2004).

While there is an emerging body of research about pathways into homelessness and the risk and causal factors leading to homelessness, there is an absence of research on pathways through and out of homelessness. There is also an absence of data on the incidence and prevalence of homelessness and in particular data that points to how long people are homeless for, the extent to which people move in and out of homelessness, and the extent of long-term or repeated homelessness. From a policy perspective it is important to understand these issues, and how people move out of homelessness in order for there to be appropriate policy responses.

The homeless pathways approach

The pathways approach provides useful insights into the complexity and diversity of people's routes into, through and out of homelessness by locating people's housing experiences, attitudes and perceptions to identify what works. This draws on the theoretical work of Clapham (2005) to show how an understanding of the agency and structural dimensions of housing pathways can result in an understanding of homelessness that "embrace the dynamics of this movement into and out of different situations" (2004: 111).

Using a life course approach to preventing homelessness and integrating this into a framework of social inclusion can help to identify needs across a person's life course. The pathways approach also breaks new ground in this sense as it focuses on the experiences, constraints, interactions and behaviours of homeless people, in areas such as household planning and decision-making, so that these experiences can be used to inform appropriate pathways out of homelessness. By bringing to the centre of the research process how

¹ A Key to the Door: The Homeless Agency Partnership Action Plan on Homelessness, 2007-2010 (Homeless Agency, 2007); Making it Home: An Action Plan for Dublin 2004-2006 (Homeless Agency, 2004); The Homelessness - A Integrated Strategy (Department of Environment and Local Government, 2000); The Youth Homeless Strategy covering young people under the age of 18 years (Department of Health and Children, 2001); The Homeless Prevention Strategy (Department of Environment and Local Government, 2002) covering people leaving state care (hospital, prison and childcare).

individuals and households experience their housing pathways can reveal insights into the extent to which individuals and households are in control of their housing pathways and how their experiences of services can enable them to live autonomously. This approach provides both a long-term and dynamic approach that is relevant to developing evidenced based policy and practice.

Research examining people's housing careers has tended to find that key life course events, such as adulthood, marriage, divorce/separation, employment and income, can impact on housing careers, whilst key factors impacting on housing choices are associated with location, quality, type, availability and cost of housing. In particular, social exclusion and traumatic or problematic life experiences can negatively affect a person's housing career during their life courses. Anderson and Tulloch (2000) show changes in housing are related to individual choice, which are affected by an individual's resources, and the availability of housing, while Clapham argues that housing is often seen as a means rather than an end in itself. This raises important issues about the extent to which people have control of their housing pathways. For example, homeless people often have little or no control over their housing options, living from day to day with little security of knowing where their bed will be for the next night. The lesson for policy makers is that attention needs to be given to measures that improve people's capacity to have control over and choice in their housing situation.

Age and gender related homeless pathways

There are specific age and gender related pathways into homelessness. Anderson and Tulloch (2000) have identified three typical age related pathways. Youth pathways are typified by loss of settled home and barriers to rehousing, difficult backgrounds, chaotic homelessness and rough sleeping. Adult pathways are typified by new and/or expanded households, relationship breakdown, release from prison, alcohol and drug dependency, mental health problems, loss of accommodation and changes in household circumstances. Later life pathways are typified by life-long homelessness, redundancy, unemployment or retirement, linked to alcohol/depression and loss of accommodation, bereavement and inability to sustain a home, death or infirmity of adult carer, marital breakdown, ill-health, late onset of dementia or other mental health difficulties.

The other main factor that influences pathways into homelessness is gender. Although there is relatively limited research on the role played by gender in housing careers, there are different pathways experienced by women and men. For example, young women are more likely to become homeless at a young age, whilst young men are likely to be 'invisibly homeless' and are the majority of those living in hostels and rough sleepers. The distinction between family and single homelessness may help explain the greater visibility of female homelessness, as many women who are visibly homeless also have children and are prioritised for homeless services. Many of these women experienced domestic violence prior to becoming homeless (Hague 1999; O'Connor & Wilson 2004).

Pathways research methodology

Bibliographical methods were used to build an understanding of the experiences of homeless pathways in order to have a dynamic understanding of how individuals and households interact with housing, and how an individual's knowledge of and meanings attached to and are affected by their experiences of their homelessness pathways. The methodology was informed by the work of Clapham (2005) in developing a comprehensive life course approach to homeless people's experiences, and work by Denzin (1999) regarding the use of biographies to highlight people's life histories and how people respond to specific life course events. This approach can help to provide a comprehensive explanation: "The emphasis on meaning and the wide-ranging nature of many discourses mean that the pathways approach tends towards holistic forms of understanding" (Clapham 2005: 111). As Clapham (2005) argues, the pathways approach focuses on importance of the perceptions and attitudes of households by using research methods that bring the interviewees' experience to the centre of the research process in order to look at how a homeless person "can control of a housing pathway and can engage with issues such as people's identity and self-esteem" (Clapham 2005: 112).

This approach can help policy makers identify more dynamic and appropriate evaluation methods in order to understand the impact and influence of housing policy on people's behaviour and their housing pathways, since housing policy can enable or prevent individuals and households from behaving in particular ways during their

life cycle. The policy framework may fail to understand the uniqueness of individual pathways, while a life course approach can address the complexity of a person's housing and other support needs in their pathways into, through and out of homelessness. Research evidence on pathways through homelessness by the Scottish Executive's Homelessness Task Force (Anderson & Tulloch 2000) found that the pathways approach requires a shift from homelessness as "a distinct phenomenon", to studies that take a longitudinal and dynamic approach so that it becomes possible to monitor changes over time and a greater emphasis on research on routes out of homelessness.

Preventative approaches

The homeless pathways approach is closely tied to the prevention of homelessness and repeat homelessness. In order for preventative policies to work in practice, there needs to be an evidence base informed by both the structural causes and the personal histories that impact on homelessness. Prevention may also be better targeted if homelessness is viewed as a process in the people's lives. This can provide a better knowledge about pathways into and out of homelessness and of what works in practice (Hagan & McCarthy 1997, FEANTSA 2004, Pillinger 2005, Watson et al. 2003). In the Irish context, it has been recognised that better recording of homeless people's biographies, better methods of needs assessment, care and case management and methods to identify repeat homelessness are integral to prevention of homelessness (Pillinger 2005). There is also a developing evidence base of the life experiences of homeless people, for example, in the case of young people (Mayock & Veki 2006), children living in homeless accommodation (Halpenny et al. 2001), women and children who are homeless because of domestic violence (O'Connor & Wilson 2004), prisoners and ex-prisoners (Hickey 2002), and drug users who are homeless (Connolly et al. 2005).

Identifying preventative actions and more innovative ways to enable people to tackle personal problems or life events is central to this. Early intervention can prevent further exclusion in homelessness, resulting from difficulties associated with mental and physical health, drug addiction, criminal activity, low self-esteem and lack of personal coping strategies (Halpenny et al. 2001, Watson et al. 2003). In the case of women experiencing domestic violence, research has identified a model for preventing homelessness, by maximising women's safety in their own homes through coordinated interventions and the development of supported transitional housing (O'Connor & Wilson 2004). Walters and East (2002) found that interventions with children were crucial to determining whether families would become settled in the future, since the behaviour of children could be a cause rather than a consequence of homelessness. Putting in place social and family supports and childcare can be critical, therefore, to prevention. Research also shows that homeless people experience an exceptionally high number of stressful events throughout their life course, particularly in their transition to homelessness (Avramov 2000). There is also a hidden homeless population who do not access homeless services, who do not appear in the homeless statistics. The Health Service Executive's research (2005) on hidden homelessness amongst young people has found that a significant number of those at risk of homelessness or experiencing homelessness do not access homeless services.

Homeless people have a number of personal, housing and social support needs, which if met can positively impact on routes out of homelessness (Edgar et al. 1999). These include personal supports in meeting everyday health and care needs; housing supports in providing advocacy, information and assistance in finding transitional and long-term accommodation and dealing with local authorities and landlords; and social supports in the developing of living and work skills, information and counselling in finding training and employment. Support needs may be temporary and targeted for some groups who have transitional support needs, for example, some young people, lone parents, women fleeing domestic violence, and ex-offenders. In other cases, people with drug or alcohol addiction problems, people with mental or physical health problems, older people and people with physical or learning disabilities are likely to have support needs that are enduring and/or permanent.

Research has emphasised the importance of support for homeless people in moving out of homelessness. Support needs in resettlement include: housing and related health needs, personal support, daily living skills, financial and social needs. Pleace (1995) highlights the connections between household problems and strategies and the need for addressing these through customer-led resettlement support by addressing care and other

support needs as well as daily living skills, self-esteem and confidence. Douglas et al (1998) highlight the use of floating support for formerly homeless people whilst Petch et al. (2000) show the importance of person-centred approaches to needs assessment that emphasise choice and provide advocacy in accessing services, and support to enable people to sustain tenancies in the long term.

Pathways into, through and out of homelessness: evidence from the research

Pathways into homelessness

The range of factors that affect people's life chances include income, access to employment and housing, whilst poverty is the major underpinning factor influencing pathways into homelessness (Anderson & Tulloch 2000, Pillinger 2005 and 2007). However, there are two problems with current policy discourses. The first is that homelessness is viewed as a marginal problem affecting a relatively small number of people, many of whom experience complex social and personal problems. Second, this can work against a preventative approach since the effect is to disassociate homelessness from the social processes and contexts that generate it. Therefore, tackling homelessness through costly emergency services causes the continued social marginalisation of homeless people; this is exacerbated by the problems inherent in the system which force many people to stay in emergency services for long periods of time simply because there is no long-term accommodation to move them on to.

The risk factors, as well as the barriers and obstacles faced by homeless people in accessing the labour market, can be explained by four sets of factors: social, personal, institutional and market factors. Individual characteristics and life experiences that affect people's homeless pathways, including age, gender and difficult life course experiences such as early childhood abuse, institutional care, alcohol and drug abuse. The Homeless Agency's comprehensive strategy to prevent homelessness provides some insights into the social context within which homelessness occurs and therefore how it can be prevented (Pillinger 2005). Access to social rights, marginalisation from the labour market, unemployment and lack of employment opportunities are also closely connected to people's pathways into homelessness (Pillinger 2004 and 2005, European Foundation 2002a and 2000b). The pathways approach is important in relation to this because employment opportunities are also affected by different life course events such as access to education in early years, family support in middle years and services to support older people and their employment in later years. As well as the risk factors, there are events that can trigger homelessness. This is exemplified in Mayock and Veki 's (2006) first phase of a longitudinal study of youth homelessness in Dublin which showed the importance of early intervention to address the risks of homelessness resulting from young people's experiences of state care, household instability and family conflict, and negative peer associations and problem behaviour, particularly in avoiding a culture of youth based homelessness that negatively affected their well-being and security.

The evidence from homeless people's biographies in the homeless pathways research, found a range of causal and risk factors that are linked to structural, social and personal/individual factors, as well as life events and triggers that can result in homelessness becoming a reality. In the research the four most commonly cited underpinning risk factors were a lack of resources, unemployment and poverty, lack of suitable and affordable accommodation at the time of a crisis, and no social and family networks to turn to. A loss of tenancy was the most significant factor triggering homelessness for women, whereas ill-health was a more common cause identified by men who experienced homelessness. Other risk factors and triggers that people experienced that led to their homelessness included: loss of a tenancy and insecure housing, marital breakdown, family breakdown, alcohol and/or drug addiction, mental ill-health and stress, voluntarily giving up a tenancy because of victimisation/harassment, leaving a mental institution or prison, loss of tenancy because of anti-social behaviour, and young people leaving the care system.

Key life course events, such as adulthood, divorce/separation, loss of employment, low income and traumatic or problematic life events were found to impact on pathways into homelessness. In particular, poverty, coupled with weak or broken family and social ties, are common underlying risks of homelessness. Factored into these are life course events related to key youth, adult and later life age-related pathways into homelessness, as well as differential pathways as experienced by women and men. These risks are influenced by the availability and affordability of housing, the security of housing and the housing choices available to people. There are

important lessons for policy makers about improving people's capacity to have control over and choice in their housing situation so that they are not at risk of homelessness, particularly where this is triggered by a significant or traumatic life event. As a result improving understanding of the causes and complexity of homelessness needs to be situated in a preventative approach, that makes it possible for people to be supported in tackling personal problems or life events that can lead to homelessness or repeat homelessness.

It is difficult and problematic to categorise people's pathways into homelessness into a single causal factor since there are a range of complex factors that impact on a person's pathway into homelessness. The pathways research showed that a large number of homeless people are not visibly homeless in the initial stages of their homelessness, often because they are staying with friends or family members, sleeping rough or living in various forms of temporary accommodation. One of the most difficult areas for prevention is in tackling homelessness at these invisible and early stages, as often this is the hardest stage for homeless people to engage with service providers.

Pathways through homelessness

The second part of the homeless pathways dynamic is to understand homeless people's pathways through homelessness. By focussing on the experience of living in homelessness, it is possible to understand how people negotiate with and take up services, the role that services play in enabling people to take routes out of homelessness, what works, and the blockages and barriers that exist. Pathways through homelessness are affected by the same range of structural, social and individual/personal factors that affect pathways into homelessness. They can be cause and effect of enduring problems that lock people into homelessness.

The pathways research found that pathways through homeless are diverse and complex. This requires a range of flexible, integrated and diverse supports and interventions that are administered depending on whether the client's experience is temporary, transitional, episodic or chronic. Temporary homelessness can and should be resolved quickly through the provision of accommodation and appropriate supports. It can be transitional, whereby an individual or household is provided with temporary transitional accommodation and supports for independent living. However in some cases homelessness becomes episodic, whereby an individual or household moves in and out of homelessness, and where homelessness is a regular and recurrent experience of their life course biographies. In some cases homelessness can be chronic and long-term and is typified by moving from one service to another, sleeping rough, living in squats and temporary rented accommodation, and periods living in transitional and long-term housing. People in chronic homelessness have significant and often complex support needs.

Homelessness has associated risks of other more enduring social problems and marginalisation typified by low self-esteem, poor coping strategies, stress, complex addiction related risks, as well as mental and physical health problems. The research found that the longer a person is homeless the harder it is to engage with services and to have a defined pathway out of homelessness, but engaging with services was not easy for many people. Single men were the least likely to present themselves at an early stage to the Homeless Person's Unit for temporary accommodation and were the most likely to sleep rough or stay with friends/relatives. Parents with children tended to find some temporary accommodation, including staying with friends or family, before presenting themselves as homeless to the Homeless Person's Unit. Other issues relate to the needs of children who are living in unsuitable accommodation and poor living conditions, and health problems, including poor mental health, which often results in low self-esteem and social stigma. The majority of single people interviewed had slept rough from time to time during their pathway through homelessness.

Several people's biographies revealed the impact that homelessness had on their levels of stress and coping strategies and how drugs helped them to cope with the risks, fear, anxiety, depression, stress and low self-esteem associated with being out of home. For some people pathways through homelessness are temporary and resolved quickly, whilst for others there are multiple living situations. Some people have moved between emergency and short-term accommodation for long periods of time. During this time there was often a loss of family and other social networks. In Mayock and Veki's (2006) research it was found that the longer young people were engaged with rough sleeping and temporary homeless hostel accommodation, the more they were likely to develop a street based youth homeless 'scene' focus to their lives, that is typified by risk, addiction and criminal activity, and a break with their communities, homes and families. The crucial point is that the longer

young people are in homeless services the harder it is for them to have a quick and easy transition out of homelessness (Mayock & Veki 2006, Hutson & Liddiard 1994).

The biographies reveal the factors working for and against people's pathways through homelessness. One of the most enduring problems for homeless services is that too many homeless people are locked into homeless services or emergency accommodation, either because of inadequate long-term housing for them to move into or because the problems that they present – addiction, mental health difficulties, behavioural difficulties – keep them away from mainstream services. Many people live for long periods of time in emergency homeless services, hostel and bed and breakfast accommodation that are inappropriate to their needs simply because there is no suitable accommodation for them to move on to. These services themselves can exacerbate exclusion and make it difficult for people to move out of homelessness.

Pathways out of homelessness

The third part of the pathways dynamic is securing long-term pathways out of homelessness. There is a need for a multi-faceted approach to ensure that people can have long-term pathways out of homelessness through appropriate long-term accommodation, support services, access to education and training, and better coordinated and integrated service provision.

The most important factor contributing to pathways out of homelessness is the provision of adequate, secure and affordable housing. Coupled with this is that the provision of support services – including family support, tenancy support/sustainment and key worker support, mental health support and family support – are also critical to sustaining pathways out of homelessness in the long-term. However, the provision of adequate, affordable and appropriate housing is fundamental and once this is in place, support and care needs that are often neglected or difficult to organise if a person is in homelessness can be put into place and tailored to the situation faced by an individual or household. The research also shows that a number of individuals and households will continue to need regular support, resettlement and care provision in order to sustain them in autonomous households, whilst for others it is simply the provision of adequate and affordable accommodation that is necessary.

Successful pathways out of homelessness encompass a combination of prevention, crisis intervention, intensive and relevant targeted support, and supporting people into autonomous and independent living situations in transitional and long-term accommodation with appropriate support services. There is a very important role played by regular contact with key workers/support workers in helping people to be independent and autonomous in their lives. Formerly homeless people were asked, in their biographies, to identify what had worked and what were the main barriers in their pathway out of homelessness. In some cases a pathway out of homelessness begins when there is a willingness to make change and take up services; sometimes this happens when a person reaches rock bottom or when something triggers a realisation of the need to make a change; in other cases the pathway begins when there is engagement with services.

All of the homeless people's biographies refer to the importance of engaging with public services as the key to a pathway out of homelessness. A major issue raised is the way in which homeless people are treated by public services (including health, housing, social services, employment and social welfare services). Homeless people spoke about their regular experiences of poor customer services, being treated with a lack of dignity and respect, and poor access to information about services. People's experiences are that a significant role is played by key workers and support workers in advocating for and enabling homeless people to engage with public services, and in providing access to information about entitlements and where to find services.

Overall the barriers identified in moving out of homelessness include a lack of access to secure, affordable and adequate temporary and long-term accommodation, a lack of access to employment opportunities and other activities, significant amounts of time spent homeless, problems resulting from alcohol and drug addiction and mental health difficulties. Homeless people identified a number of factors as working in facilitating their journey out of homelessness. These include access to good quality temporary, transitional and permanent accommodation; limits on the time spent in temporary accommodation, particularly with children; having choices in where they lived and the type of housing they lived in; being treated with respect and dignity and listened to; building capacity and skills to be independent and autonomous; having needs met in a person-

centred way; and having access to information, advice and assistance. Whilst many people identified the need for support in daily living, cooking, budgeting, managing resources, managing tenancies and independent living, many referred to the need for ongoing support, advocacy and assistance to be provided once someone is permanently settled and access to support workers when a crisis occurs, or support after permanent settlement. Many of these issues show that the barriers that people experience could more easily be addressed through prevention, including improved supply of affordable accommodation, early intervention and attention to the structural causes and individual risk factors that lead to homelessness. There is a very important role played by regular contact with key workers/support workers and particularly in helping people to be independent, autonomous and confident in their lives.

Conclusions

This chapter has shown how a pathways approach to homelessness can help to provide a more dynamic and comprehensive picture of the experiences of people who are out of home. In particular, it challenges policy makers and service providers to see the bigger picture of homelessness and how policy and service interventions need to be designed and provided through a life course approach that takes account of the causes and triggers of homelessness, as well as the problems and barriers homeless people face in gaining independence and autonomy in their lives. Homelessness is neither a group characteristic nor a static condition, rather it is a process that can be viewed as part of a continuum of situations impacting on disadvantage and homelessness across the life cycle. The pathways approach is designed to inform housing and homeless pathways and to explore a broader definition of homelessness that incorporates the experiences of those who are at risk of homelessness, and to identify the dynamics between visible and less visible forms of homelessness. This makes it possible to explore how the relationships and patterns that arise between and at the different stages of individuals' housing and homelessness experience can inform the development of appropriate routes out of homelessness with supports and interventions which seek to prevent repeat homelessness.

The provision of affordable, secure and good quality housing is central to long-term pathways out of homelessness. However, many people are staying long-term in inappropriate accommodation through a lack of supply of affordable, secure and good quality privately rented housing and social housing. Gaps exist in the provision of emergency, transitional and longer-term housing options, particularly for single homeless people. Homelessness could be prevented at an early stage through the provision of appropriate accommodation, with support services where they are needed. Due to the shortage of affordable and good quality privately rented accommodation and social housing, many of the people that participated in the homeless pathways research had remained in homelessness for longer than was necessary. This situation appears to have worsened in the last year with more limited access to long-term accommodation and affordable accommodation.

The research has shown that homelessness strips people of dignity, independence and autonomy. Building the capacity of homeless people, so that they can live independently and autonomously, requires more effective service coordination, access to affordable and secure accommodation, and personal support in daily living. Equally important is that homeless people attach particular importance to their lives of being treated with dignity and respect, particularly by service providers. Many homeless people have stated that stigma and a lack of dignity further reinforces their exclusion from services, and their own levels of self-esteem and confidence. Many people spoke about their sense of degradation, exclusion and humiliation that resulted from their homelessness and how this was reinforced in their engagement with public services. In addition, there are gaps in the provision of a range of services, including detoxification and rehabilitation facilities, in community-based mental health services and other support services, and poor access to knowledge of information about rights and entitlements. A commonly shared barrier is a lack of information and understanding of how to seek help and advice, particularly when people are at their most vulnerable.

The longer an individual or household is homeless, the greater the likelihood that they will be exposed to a second layer of risks and dangers in their lives, including social exclusion, social problems, mental health difficulties, alcohol and drug addiction, service exclusion and exclusion from mainstream society, family, friends and local communities. The homeless pathways biographies illustrate the impact of being out of home on social exclusion, and that there is an adverse connection between length of time in homelessness and engagement with services.

There are generally higher levels in the homeless population compared to the general population, of complex and problematic drug or alcohol use, and physical and mental ill-health. For this group of homeless people, housing pathways are often complex, involving temporary, unsatisfactory and unstable housing and further or repeat homelessness. Being out of home exacerbates many of these problems, creating a vicious circle of marginalisation and exclusion. Addressing them through appropriate housing, health and other supports will not only save people's lives, but it will enable people to have access to lives of dignity and autonomy.

These findings suggest two related issues need to be taken on board by policy makers. First is the need to reorientate policy and resources to a pathways and preventative approach. Second, are the inter-related issues of housing supply and reducing the need for temporary and emergency accommodation in favour of sustainable housing.

The homeless pathways research does show that, from the experiences of homeless people, effective responses that impact on pathways out of homelessness include a combination of access to accommodation, support services and preventative measures. The research on homeless pathways identifies four critical areas that need to be addressed in policy and service provision in order to prevent homelessness, and facilitate pathways through and out of homelessness.

First, is the need to improve access to long-term accommodation in privately rented, local authority or social housing schemes, with or without floating and flexible support. It is critical that there is better access to privately rented housing, through extension of programmes such as the Rent Assistance Scheme, and access to accommodation with rent allowance and assistance through the Access Housing Unit. Preventative measures need also to focus on improved access to housing advice and information, access to rent deposit schemes to improve access to privately rented accommodation for potentially homeless people, and improvements in the supply of affordable, secure and good quality rented accommodation. There will continue to be a need for access to transitional accommodation and supported or group accommodation schemes for specific groups, for example, young people, women fleeing domestic violence, families with children and single men. In addition, schemes and supports to enable people to remain in their current accommodation will be important to avoiding eviction resulting from debt, anti-social behaviour, or family breakdown. A priority should be to ensure that no family reside in bed and breakfast or emergency accommodation for more than one month, with adequate move-on accommodation and care and case management planning.

Second, is that ongoing flexible and responsive support services, including services to prevent a crisis arising are central to the prevention of homelessness or repeat homelessness. It has been shown that supports are essential if people are to gain confidence, capacity and autonomy in areas such as budgeting, parenting, engagement with service providers, and access to and participation in training and employment. Tenancy sustainment and support services, family support services, supports for people who have left institutional care, specific coordinated supports for people experiencing ill-health and mental ill-health, can all be provided more effectively once a person has long-term accommodation.

Third, a higher priority is needed in the area of training and work to improve access to appropriate training and educational guidance supports to enable people's learning choices and pathways, improved access to work experience and work placements, as well as opportunities to gain good quality employment. Employers need also to be made of aware of the barriers faced by homeless or formerly homeless people in entering the labour market, and incentives should be provided to employers to employ homeless or formerly homeless people.

Fourth, is the need for more long-term preventative measures that are aimed at avoiding or averting a personal crisis that could lead to homelessness, for example, through family mediation services, domestic violence support services, and support with young people's transitions. Other longer term preventative measures include awareness of housing issues in school education, early intervention in families experiencing difficulties and where there are disputes between families and children, identifying children at risk from a young age, and building effective care teams to assist young people leaving HSE care. Adult/late life initiatives include specialist preventative work with at risk groups such as people with addiction problems, housing information and advice in prisons and support leaving institutional care.

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Youth homelessness

Chapter 8:

Young people's pathways through homelessness: the offender-victimisation nexus

Paula Mayock

CHAPTER 8 YOUNG PEOPLE'S PATHWAYS THROUGH HOMELESSNESS: THE OFFENDER-VICTIMISATION NEXUS

PAULA MAYOCK

Although categorised as 'at risk' or vulnerable, homeless young people are simultaneously often perceived as a risk themselves and, therefore, dangerous. Many without homes 'signify disordered space' (Harter et al. 2005: 316) and, as an undesirable public presence particularly in the context of street begging, are considered a threat because of their presumed role as perpetrators of crime. There is of course considerable evidence that criminal activity is common among the young homeless. Living on the streets or without stable accommodation contributes to youth crime, arrest and committal to prison (Hagan & McCarthy 1992; 1997), and being homeless cultivates involvement in deviant strategies (Gaetz & O'Grady 2002, Hagan & McCarthy 1997, Whitbeck & Hoyt 1999). Recent research by Baron (2007a) found that while some homeless youth in one Canadian city had little or no involvement in criminal activity a significant number were repeat offenders. High rates of criminal activity among homeless youth and adults have also been documented in other North American studies (Gowan 2002, Snow et al. 1989, Snow & Mulcahy 2001). Irish research is limited in this area but there is evidence that criminal activity and incarceration are common among the homeless (Hickey 2002, Seymour & Costello 2005).

A distinctive feature of homeless youth lifestyles is the range of money making strategies they may use at different times and for different reasons. Whilst it has been claimed that most homeless youth want to participate in the labour market (Gaetz & O'Grady 2002), the vast majority face enormous barriers to obtaining and maintaining employment because of their limited education and skills training. As a consequence, many resort to theft, robbery or selling drugs as a means of generating income¹. Indeed, the criminal activity of homeless youth is claimed to be strongly associated with the basic subsistence strategies they use to generate money, meet everyday needs, or buy drugs (Hagan & McCarthy 1997, Snow & Anderson 1993). Moreover, research evidence also suggests that the longer youth spend on the streets, the greater their risk of becoming involved in 'risky' or deviant behaviour. Street life is said to be 'criminogenic' in that it fosters both the opportunity and necessity for criminal behaviour (McCarthy & Hagan 1991). Conversely, high participation in unconventional subsistence strategies increases young people's visibility and vulnerability in the street environment, which leads to an increased risk of victimisation (Tyler et al. 2001, Whitbeck & Simons 1993). Thus, a singular focus on homeless youth as potential offenders 'overlooks the real possibility that they may disproportionately be victims of crime' (Gaetz 2004: 424).

A significant body of research now suggests that young people who are homeless experience much higher levels of criminal victimisation than their domiciled peers (Ballintyne 1999, Carlen 1996, Lee & Schreck 2005, Newburn & Rock 2005, Wardhaugh 2000). Homeless youth are said to have life courses wrought by violence (Baron 2003) and a burgeoning literature is exploring the myriad and complex factors that produce these higher levels of victimisation (Baron 1997, Gaetz 2004, Fitzpatrick et al. 1999, Lee & Schreck 2005, Pain & Francis 2004, Tyler et al. 2000, Tyler & Johnson 2004, Whitbeck et al. 1997, 2001). Much of the available research has focused on experiences of victimisation prior to becoming homeless and there is emerging consensus that large numbers of homeless youth come from homes characterised by high levels of physical, sexual, or emotional abuse and neglect (Ringwalt et al. 1998, Whitbeck et al. 1997, 2001, Whitbeck & Hoyt 1999). The street is increasingly recognised as a context where victimisation is likely because of young people's limited guardianship and their exposure to potentially dangerous places and people. Research has, for example, established homeless young people's vulnerability to violent victimisation on the street including being attacked, beaten or sexually assaulted (Gaetz

¹ While there has been relatively little investigation of the subsistence strategies of the homeless in Ireland, one study of older homeless men found begging, unemployment assistance, smuggling, casual employment and theft to be their main sources of income (O'Sullivan, 1993).

2004, Kipke et al. 1997). It has also been claimed that the longer young people are homeless, the greater the risk of victimisation (Lee & Schreck 2005, Kipke et al. 1997, Whitbeck et al. 1997, 1999, 2001). More recently, research has drawn attention to an interaction between criminal offending and victimisation among the homeless and there is now growing recognition that 'offender' and 'victim' are not necessarily exclusive categories. For example, Pain & Francis (2004) have argued that the marginal spaces occupied by homeless youth make them susceptible to both perpetuating crime and becoming an offender. Likewise, Tyler and Johnson's (2004) qualitative exploration of the pathway into the victimisation-offending process suggests that young people's experiences of crime and victimisation are strongly connected.

This paper examines the settings and circumstances that give rise to offending and victimisation among the young homeless based on selected findings from a longitudinal study of youth homelessness in Dublin. The data demonstrate that criminal activity and victimisation were commonly reported and they were mutually reinforcing rather than disconnected entities or experiences. The marginal spaces occupied by homeless young people propelled many into situations where they were more likely to offend and to also be victims of crime. As 'careers' in homelessness progressed, the social stigma they faced further exacerbated the risk of both offending and victimisation. It is argued that new approaches and strategies are required to recognise and address the realities of street life and to ensure that young people who experience homelessness do not enter into a cycle of repeated incarceration which ultimately serves to prolong their homeless 'careers'.

Homeless pathways

The findings presented in this paper are drawn from a longitudinal qualitative study of homeless young people in Dublin city (Mayock & O'Sullivan 2007, Mayock et al. 2008). The study adopted a pathways approach, which acknowledges the diversity of the homeless experience and its susceptibility to change over time (Anderson & Tulloch 2000, Clapham 2002, 2003), thus eschewing cross-sectional or single point-in-time research strategies which can present a distorted picture of the nature and duration of homeless experiences (Anderson & Christian 2003). Examining young people's routes into, through and out of homelessness, this biographical approach to interviewing young people's 'life stories' privileges their understandings and interpretations of their situations over time. It is the first study of its kind to be undertaken in an Irish context.

The research was conducted in two waves: the first between September 2004 and January 2005 and the second between September 2005 and July 2006². During the first wave of data collection (Phase I) life history interviews were carried out with 40 homeless young people. Contact was re-established with 32 of these respondents during the second wave of the study (Phase II) and information regarding living situations was collected on an additional five young people. Information was, therefore, available on 37 of the 40 young people interviewed during Phase I. Of these, a total of 30 were re-interviewed during Phase II data collection³.

Childhood victimisation

Consistent with the international literature, a large number of the study's young people reported home-based difficulties as children as well as disruption to family life linked to one or more of the following: parental illness or death, family conflict, parental drug or alcohol abuse, neglect and/or experiences of violence or abuse. Other reports of childhood disruption included strained family relationships, sometimes in tandem with domestic violence. Four stated that they had witnessed violence against a family member (usually their mother or siblings) and a further seven reported an episode or prolonged period of physical abuse by a parent or caregiver in their homes during childhood. Conflict arising from the presence of a step-parent was reported, with these young people typically reporting tense or extremely difficult relationships with a parent's new partner (most frequently, a stepfather). For some, running away became the solution to violent home situations that became increasingly difficult:

Well I'm on the streets about six, seven months. I used to get beatings at home and all by my stepfather and all. My real father is dead and my mother, she's an alcoholic and she always drinks and all. And any time she gets drunk an' all and he gets drunk he always beats me up. And that's how I ended up being on the streets. Came into town and stayed on the streets, going into hostels, shit like that and all, you know what I mean. –

Gavin (15)

² It is hoped that a third wave of data collection will commence in September 2008. This third phase will seek to track the study's young people once again and conduct a second follow-up life history interview.

³ See Mayock & O'Sullivan (2007) and Mayock, Corr & O'Sullivan (2008) for a detailed account of the study's methodology.

During Phase I, an additional three young people (one young man and two young women) reported sexual abuse during childhood. The perpetrator of abuse was a family member in two cases and a stepfather in the third. When asked about growing up, Shane told how he never really had 'a life' as a child:

Well my life was brutal like, you know. My father abused me. I'm gay, my mother will tell you that. He (father) raped me when I was younger so like, you know, I've had a brutal life, he beat me up ... I didn't really have a life as a child. – Shane (22)

By the time a large number first experienced homelessness, they had been victims of violence associated the misuse of parental or carer power through some combination of emotional, physical and/or sexual abuse. It also appears that some left home prematurely in an effort to escape these violent or abusive contexts. However, young people confronted a range of difficulties and challenges on becoming homeless, confirming that leaving home situations characterised by violence, abuse or other such adversities may serve more to exacerbate victimisation rather than to alleviate it (Whitbeck & Simons, 1990).

Hostel and street 'scenes': spaces of opportunity and risk

The condition of homelessness 'forces individuals, whose claims to community citizenship are routinely contested, to negotiate and survive in spatial domains that were neither designed nor intended for residence and basic subsistence activities' (Harter et al., 2005: 312). Although homeless youth are often less visible than older homeless people⁴, the absence of a stable home means that there are times of the day (and night) when they have no option but to locate themselves in very public environments where their presence is conspicuous. The majority of this study's young people entered into the official network of homeless youth through the Out of Hours Service (OHS) during their teenage years. This service, which is accessed by young people after they present as homeless at a Garda station, is based in the city centre of Dublin. The emergency under-18s hostels (residential settings) where young people are subsequently placed are also located in, or adjacent to, the city centre. While a number moved from emergency to more stable accommodation relatively quickly, others embarked on a cycle of movement between multiple temporary living situations. This movement was enduring in many cases, persisting for months or even years, as they alternated between emergency hostels, the street, and other temporary living places.

Unsurprisingly perhaps, the transition out of home proved difficult. First days and weeks were dominated by feelings of uncertainty about the future and the challenge of adjusting to their new living situations was also considerable. The high turnover of clients entering and leaving emergency accommodation (hostels) meant that young people constantly encountered new faces and this transience provided few opportunities to build stable or secure relationships. Perhaps more than anything, young people's accounts of hostel life reveal the significance of 'coming into town' (i.e. to the city centre) to access this accommodation (Mayock & O'Sullivan 2007). Indeed, much of the evidence suggests that the geographical location of accommodation designed to cater for young people in crisis posed a risk to their safety and served to enmesh them in 'scenes' for which they were ill-prepared.

Upon entry to the official network of homeless youth, a large number were introduced to different niches within the street economy, the vast majority increased their drug and alcohol use, and many became involved in a range of illegal or quasi-illegal money-making activities. At Phase I, half of the study's young people were heroin users and the majority of these acknowledged that their drug use was problematic to the degree that it had become a dependency. Additionally, three-quarters reported 'trouble' or had been cautioned by the police, approximately three-quarters had been charged with a criminal offence, and almost half had been incarcerated at some time. Law-breaking ranged from minor violations to more serious criminal activity and was strongly associated with the daily challenge of survival:

Robbing cars, muggings, all that. I had to do it to survive. I mean you have to have clothes on your back, and you have to have food in your stomach. – Julian (22)

Money, I go off robbing for money. If I have to make money I have to go off and make it myself. No problem, I go off stroking (robbing). – Joe (19)

⁴ Homeless young people may be less likely to live on the streets because most are (at least initially) placed in temporary hostel accommodation. Others may reside intermittently in squats or the home of friends.

I would steal my food and if I needed deodorant I had to nick it and if I wanted food I had to nick it. – Neil (20)

I've robbed an' all ... I robbed a pair of trousers before I came here (to the hostel) 'cos I had only one pair of jeans. So that was it, I needed stuff like. – Rachel (14)

While theft was the most commonly reported subsistence strategy, drug dealing emerged as another method of offending for survival or financial gain. Indeed, some reasoned that they could earn little by 'tapping' (begging) compared to the financial reward of selling drugs. One young man told about a period when he dealt drugs in return for a place to sleep. Whilst this arrangement made economic sense, it also carried significant risks:

... I was staying with a friend of mine for, em, about seven or eight months. But the down side of staying in this friend's was that I had to go out in the mornings and sell heroin for him and I kind of messed up ... I was smokin' everything I was getting but he was making a good few quid. But I was feedin' my habit and had a place to stay so, you know what I mean, it was handy enough for me. – Brendan (17)

A considerable number had been charged with drug-related offences (possession and/or supply) over the course of the study. Involvement in drug dealing activity was invariably related to the need to generate income, often to finance drug use or dependence. Fergal described himself as a 'social' drug user at the time of his initial interview but subsequently initiated heroin use and started to deal drugs. His Phase II account locates both of these transitions in the context of the people and places he encountered as he moved between living situations:

After that (first interview) I left (hostel accommodation) I went into (transitional housing). I was out around town, hanging around and that and I got in with the wrong crowd. An older crowd and I got into gear, started smoking gear. Then they got into selling gear. I was holding stuff in me gaff, nice quantity, but was supposedly under surveillance for six months and the police raided me gaff. Me and two of me mates were in it, got caught with three eighths of gear, one in my room ... I took the rap for one eighth, said it was for me own use, the other two denied it ... That's fucked everything up really, I lost me gaff. I'd no income at that stage. I gotten too used to the money I was getting and I didn't give a fuck about signing on and getting me money. So I was fucked after that. – Fergal (19)

Within the settings where they socialised, young people experienced pressure to conform to the norms and 'rules' of street life and there were also strong incentives to adhere to these expectations. Being streetwise was essential to the process of integrating and included a broad spectrum of abilities and adaptations: a reliance on instinct and experience to read situations, a preparedness to respond, integrate and interact, and a general awareness of the material and symbolic make-up of the social environment. Without this stock of knowledge or street savvy, daily life would be challenging and risky. For those who commuted between emergency or short-term hostel settings, talk about the need to present as macho or 'tough' was also commonplace. These outward displays of invulnerability also necessitated the espousal of attitudes and strategies that were perceived to serve a protective role:

You have to stand up for yourself or they just walk all over you and they just keep on doing it you know. You just find yourself in that situation and you'll probably just snap one of the days and you'll end up killing (beating up) somebody like. You'd want to stand up for yourself. You learn that after a while, after being bullied for a while. – Eoin (20)

Such perspectives on 'survival' were often related to the hard lessons youth learned on the street, including personal experiences of bullying and exposure to violence. Some openly admitted to resorting to violence in situations where they felt compromised by the threat of aggression:

I've seen blokes, I've done it personally myself, I've seen blokes left in fuckin' puddles of blood, d'you know what I mean, just for their money. It's bad. – Christian (17)

It is important to be clear that not all study participants were involved in persistent or violent criminal activity. The majority of offences reported fall into the ranks of more minor misdemeanours and could be classified as offending for the purpose of survival or financial gain. Of major significance however, and critical in terms of understanding the relationships between homelessness and criminal behaviour, is that involvement in

lawbreaking continued or increased in the case of those who remained homeless by Phase II⁵. Of the thirteen young people who failed to exit homelessness, eleven had been incarcerated since they first left home. Paul, who was out of home for at least four years at the time of Phase I, claimed during his initial interview that the years he spent moving between temporary hostels served to propel him towards lawbreaking as a core subsistence strategy:

When I came into town (pause) ... I was 14 or 15 when I came into town ... like you're trying to fit in, you know. Away from home town is a totally different place so you're trying to fit in with people. You just go along with it and just see what happens like. Know what we used to do actually, this is when I first started mugging people ... like we'd stand at a bus stop, and we'd just suss out a few people, you know. Like just get on the bus then with them and we'd be sitting behind them, in front of them, at the side of them or whatever and we'd get the stuff off them then and then just straight back off the bus. And the bus would just be gone then, you know. So that was the first few, yeah, my first few muggings. – Paul (19)

By Phase II, Paul was incarcerated. Whilst acknowledging his involvement in minor misdemeanours from an early age, he still held that his entry to the official network of homeless youth in the city centre marked a negative turning point that had become increasingly difficult to reverse:

If I didn't come into town I wouldn't be here (prison), I know I wouldn't. I don't know like. Out there (home neighbourhood) like, I'd probably could have like a robbed car charge but I wouldn't, I wouldn't be having, you know the serious bad assault an all, I wouldn't say so in any way, just in town, it's much different, it's totally different than the suburbs. When you come into the city like, it's much different. – Paul (21)

'Out of place': stigma, distrust and victimisation

On a daily basis, 'at risk' youth are bombarded with messages of distrust (Harter et al. 2005). This distrust makes meaningful relationships difficult and serves to further isolate them from the mainstream. Many in this study who had been homeless for longer talked about their limited contact with family members and the instability of their peer networks. They spent much of their time in the company of one or two others but group cohesion was often loose and unpredictable. Whether due to the lack of a stable family life or the transience and unreliability of their friendships, many were sceptical about trusting others and they also felt that they were trusted by few. The need for company in the context of predatory street scenes appeared to significantly influence their peer affiliations but these social networks rarely endowed a sense of loyalty, trust or security. Those who were homeless for longer often stated openly that they had no real or dependable friends:

I wouldn't really hang around. Just sell gear to them (friends), they're just associates. They'd rob you blind, they would. They'd take the clothes off your back. – Fergal (19)

I did have good friends, but when I started on drugs I lost all me friends and got acquaintances instead of friends. You get more associates than friends when you're on drugs, you know, you can't trust anyone. – Sarah (21)

Homelessness is of course a dehumanising experience which erodes young people's stake in society and their connections with the conventional world. The instability of their living situations is at once alienating and their weak guardianship impacted negatively on their ability to protect themselves. Young people feared the responses of others, including strangers. This fear was particularly strong in the accounts of rough sleepers:

I was very paranoid, I couldn't get asleep ... I had to try and keep one eye open because I was afraid someone would just come up and kick me out of it like. Like kicking me to death like, you know what I mean. It has happened to a few people that I know that have been basically sleeping rough and they have been kicked like. Because people who are drunk, they think it's a great laugh. They kick the homeless. – Seán (21)

For a considerable number, the dual stigma of homelessness and drug addiction constituted a 'double jeopardy' (Neale 2001) which further exacerbated their marginal status and identity. Tony's account of feeling 'out of place' illustrates his profound sense of alienation from his home neighbourhood and former peers:

⁵ By Phase II of the study, a considerable number of the study's young people had exited homelessness, either in an independent or dependent sense. Those who exited were less likely to have criminal histories or, alternatively, tended to have distanced themselves from street 'scenes' (see Mayock, Corr & O'Sullivan, 2008).

I just, I've no friends now. I'm a loner, I stick to myself. I like being on my own, I do. I can't be, I can't stand in a crowd anymore. Like when I go out to (home suburban neighbourhood) and I see my old mates I can't stand out with them because I just feel out of place. Like ya know, the way I was thrown out, they're all doing well and have jobs, driving around now they are. I can't stand it. I don't drink anymore, I just do gear like, that's it just the heroin. I just feel out of place. Even if I go into a pub I just feel out of place. I just have to get out of there like, you know, just feel out of place. – Tony (22)

The social spaces occupied by young people who remained homeless fostered feelings of isolation, making them extremely vulnerable to victimisation. While hostel and street 'scenes' opened up avenues for youth to generate income, as sites of social interaction governed by the need to survive they also encouraged and facilitated bullying and intimidation. Several who were well-acquainted with city centre hostels claimed that bullying was pervasive in these contexts and that younger groups were particularly vulnerable. There were also suggestions that coercive tactics were sometimes used by older youth to force the less experienced to engage in criminal activity:

The little kids who can't defend themselves, they're the ones that get bullied the most into doing things. – Ronan (19)

*There's a lot of bullying, yeah, with little kids. Yeah, there is. Big people bullying little kids, there's a lot of it. [What would they bully them to do?]
To snatch, rob, drugs. Anything, anything. Yeah, it happens in the hostels, it happens in the street. It happens everywhere. – Declan (19)*

Whilst it is difficult to ascertain the extent of the kinds of coercive tactics described above, there was strong evidence that young people felt unsafe both in hostel and street-based settings. Several reports also suggest that at least some feared particular individuals and groups known to them through the hostel 'scene'. One young man described victimisation by a group of physically threatening street youth:

There's a lot of bullying an' all going on around the street. There's fellas called Johnny and James and Richie, and they're all robbing me an' all every time they see me. They're all bigger than me like, they're all men like, do you know what I mean. – James (18)

Many in this study who were prolonged users of emergency or short-term accommodation lived in socially predatory environments. Fights sometimes erupted between homeless youth themselves over possessions, money or drugs, and the use of risky subsistence strategies also exposed them to potentially threatening individuals. For those who were homeless for longer, the experience of violence and intimidation was an everyday reality – a 'way of life' as one young man put it:

Ah, I've been beaten up plenty of times and I've beaten up people plenty of times. It's the way of life out there, you know, you know. Like there's always someone out there better than you at the end of the day. – Declan (19)

Up in (under 18s hostel), there was a lot of bullying going on there. Yeah, in hostels there is a lot of bullying going on. In and around town homeless people get a lot of bullying, bullying each other like. People tapping (begging), other people come up and take their money off them and give them a box, stuff like that. – Luke (20)

This evidence is consistent with previous research which has suggested that the homeless victimise each other (Snow et al. 1989). The numerous reports of having property stolen, both on the street and in hostels, indicate that most felt powerless when such incidents did occur. Young people rarely or never reported these crimes to a relevant adult authority and when questioned about disclosing incidents of bullying, intimidation or violence, many indicated that such a course of action was either unacceptable or lacking. Disclosing the transgressions of peers to service providers or other authorities signified a loss of face and could lead to recriminations and further (or amplified) trouble or violence. Taking action also meant being labelled 'a rat' and the negative consequences of protesting these injustices to staff were considered to far outweigh any personal losses involved. One young woman who had personal items stolen in the hostel where she resided explained:

... couldn't say it to the staff because obviously that's being a rat. I would have got myself in twice as much trouble. – Caroline (16)

More broadly, reluctance or refusal to report crime against their person was related to a profound distrust in the systems of intervention presumed to serve a protective function. Prominent here was the fear of victimisation by the police. A total of ten young people – almost all young men – claimed to have been victims of mistreatment by police officers. The following are two examples of such claims:

When I was around 12 or 13, they'd catch me robbin' and they'd throw me into the police van, the Garda van and they'd start pullin' hand-breakers in the van with you handcuffed in the back. I'm dead serious, you know, they'd whack you out of it with the baton like, tryin' to get information an' all. – Colm (20)

Scumbags, dirty scumbags. Like when I got nicked I was only going to be charged with breach of the peace but the copper kept hitting me in the back of the head and pushing me, trying to whack me head off the top of the car door. When I got out of the car he kept boxing me in the back of the head and there's only so much I can take ... I snapped at him, shouting ... then four coppers came out of nowhere and just battered me, gave me a shiner (black eye), the four of them milled (beat repeatedly) me. Like that's why I'm up on all them charges, they gave four: being violent in a Garda station, assault, and then two for drinking. And like it's my word against theirs and if I go out and say he hit me first, they'll say they have their witnesses. Can't fuckin' win, dirty pigs. – Fergal (18)

Noticeably lacking in the narratives of young people was a belief that they would be protected and most presumed no entitlement to such protection. This belief was also related to the shame and stigma of homelessness, which fostered a perception that they would not be trusted or believed.

On becoming homeless many found themselves negotiating 'spaces' where they quickly identified money-making opportunities and they subsequently immersed themselves in these scenes as a survival strategy. Over time, however, these same settings and contexts served to diminish their stake in society, rendering them 'out of place', relatively isolated, and unprotected.

The offending-victimisation nexus

The data presented indicate that many accounts of offending and victimisation 'are not necessarily separable, nor should they be perceived as such' (Pain & Francis 2004: 106). Young people developed distinctive coping practices as they gained exposure to street life and some began to adopt aggressive styles of interacting with others in their surroundings. Frequently, both victimisation and offending were present in the accounts of young people who described instances when they responded aggressively to the attempted victimisation of themselves or their property. Christian, homeless for six years by the time of his Phase II interview, described one violent altercation with other homeless youth:

People never robbed me. They've tried now. One or two people have tried to rob me and I had to fucking sort them out.

(And was that physically sort them out?)

Yeah, you'd have a fight. Like it's all stupid but you'd have a fight. They all came over and tried to have a fight with me in the middle of O'Connell Street of all the bleedin' places ... There was a few of his mates and a few of my mates. They came over and started swinging boxes at me, you know what I mean. I wasn't going to stand there so I gave him a loaf (hit him), busted his eye for him, you know what I mean. He never bothered me again after that, you know what I mean. But that's the way it is – Christian (17)

In the account above, the speaker might simultaneously be viewed as an offender and victim. Altercations of this kind placed young people at risk of arrest and incarceration and in these contexts their status as victims was rarely if ever recognised. During his Phase II interview, Christian talked about the frequency with which he was arrested and 'locked up'. This account is significant since he is a young man who had had no experience of incarceration at the time of his initial interview:

I fuckin' couldn't stay out of there (prison). Every time I got out of there in a couple of days I'd get arrested on the street, fuck sake, and back inside ... Every time I walk down the street, do you know what I mean, I was getting fuckin' locked up ... I was getting locked up for everything. They just wanted to get me off the street for as long as possible, you know what I mean. – Christian (19)

It seems that the tensions of street life are particularly conducive to a vicious cycle in which individuals alternate between victim and offender roles (Lee & Schreck 2005). Moreover, while homeless young people are highly likely to come to the attention of law enforcement agencies and to subsequently face arrest and incarceration, they appear not to expect or seek protection in situations where they are themselves victims of crime.

Conclusion

Consistent with other studies, the data presented suggest that in order to survive on the streets individuals must assimilate a street culture – the information, resources, values and associations – to enable them to negotiate everyday life. This process, intensified by prolonged homelessness, also serves to propel young people towards criminal activity. The findings presented also demonstrate that the victimisation experienced by homeless youth is multidimensional and often repetitive. Many came from homes where they experienced some measure of violence or abuse which impacted on their decisions about leaving home. This finding is consistent with a recent study of 'out of home' young people in Cork city (Mayock & Carr 2008) and confirms that homeless young people may have early life experiences characterised by violence and victimisation. Some argue that abusive experiences and events continue to influence young people once they become homeless and that being the victim of physical abuse increases street youth's violent behaviour on the street (Baron 2007b, Baron & Hartnagel 1997, 1998, Whitbeck & Simons 1990). However, this thesis does not explain how some come to learn and engage in criminal activity subsequent to becoming homeless, nor does it fully elucidate the processes and experiences that give rise to victimisation on the street. A more persuasive explanation for the high rates of offending and victimisation among this study's young people relates to the social spaces and environments they entered on becoming homeless. Hostel and street life exposed many to incentives to engage in criminal activity and simultaneously placed them in settings where they were likely to be victimised. As homeless careers progressed, this dynamic intensified due in large part to young people's restricted access to legitimate sources of protection. This finding strongly suggests that 'offender' and 'victim' are not mutual categories but 'represent a homogenous pool in which offenders are victimised and victims also offend' (Tyler & Johnson 2004: 427).

The claim that exposure to victimisation among the homeless is enhanced by their concentration in inner-city locations (Lee & Price-Spratlen 2004) is largely supported by the findings presented. Young people who embarked on a cycle of alternating between emergency or crisis-orientated services were particularly vulnerable, not least because of their increased susceptibility to drug use and dependence. It also seems clear that the stigmatisation of the homeless created a 'double bind', leading them to distrust others and to have limited or no access to individuals or agencies routinely presumed to serve a protective function. As victims of crime, young people in this study generally relied on a narrow set of social supports and, as a consequence, many engaged in strategies that served to marginalise them further.

Research, as well as public perception, has tended to focus on the criminal activity of homeless youth. Moreover, the systems of intervention targeting young people in crisis, although well-intentioned, can serve to push at least some towards activities that have an uncertain or negative impact on their futures. Although held accountable for breaking the law, homeless youth have no reciprocal protection for crimes committed against them. It seems therefore that those children and young people who fall through the net onto the streets, often following experiences of abuse, are highly likely to be demonised and criminalised by the society that has failed them. As Carlen (1996: 139) puts it:

... the lives of these so-called 'marginal' young people have been shaped and reshaped by asymmetries of citizenship which have punished them for both their own misfortunes and misdeeds and those of their families, at the same time as excluding them from even minimal rights to sustenance, shelter, personal security and the redress of wrongs committed against them.

It is perhaps unlikely that the findings presented here will alter public perception of homeless youth as potential offenders but they may assist professionals and policy makers to broaden their vision of the range of experiences that characterise being young and homeless. Homelessness places young people 'in the contradictory position of being at risk for criminal victimisation, on the one hand, and the target of public efforts to control crime and deviance, on the other' (Gaetz 2004: 447). Incarceration as a 'solution' to homeless youth who offend not only serves to further enmesh them in a culture of homelessness but also fails to recognise their limited access to protection and to mechanisms that might support them in exiting homelessness.⁶

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⁶ I wish to acknowledge the contribution of Dr. Eoin O'Sullivan, School of Social Work and Social Policy, Trinity College Dublin, and Mary Louise Corr, Children's Research Centre, Trinity College Dublin, to the larger study from which the findings presented in this paper are drawn.

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Homelessness and housing

Chapter 9:

A place to call home? Issues in housing provision for homeless persons

David Burke

Chapter 10:

Domestic violence and homelessness: a practitioner's perspective

Sharon Cosgrove

CHAPTER 9

A PLACE TO CALL HOME? ISSUES IN HOUSING PROVISION FOR HOMELESS PERSONS

DAVID BURKE

Introduction

The very substantial effort and monetary investment being made in homelessness is fundamentally compromised because the key ingredient of access to a home is not currently achievable for the majority. By painting a picture of the key dynamics and principles at play in housing access for those who are emerging from or vulnerable to homelessness this practitioner's perspective serves to promote an appreciation of the complex subject and posit how it might be addressed. The essay does so by interrogating the vehicles held to provide a pathway to housing for those needing access to a home.

Context

As a pre-requisite to exploring the issue of housing access and homelessness in Ireland we should acknowledge a fundamental reality of our housing system. Figure 1 describes the dichotomy in our housing system where a 'glass ceiling' represents the division between those with an aspiration of mainstream housing (i.e. owner-occupation) and those who have no real chance of owner-occupation and represent an excluded minority consigned to marginalised, residualised tenures. The 'glass ceiling' represents a real demarcation and those below the line compete against the weight of our mainstream housing system whose hegemony is reflected structurally in our society through for example the fiscal and legal treatment of owner occupation. It is within the arena of the secondary, welfare based housing below the line that the homeless compete for access to homes. Here also educational attainment, economic participation and life chances are all distinctly lower. It represents where vulnerability and need settle at the bottom of our society and become self-fulfilling.

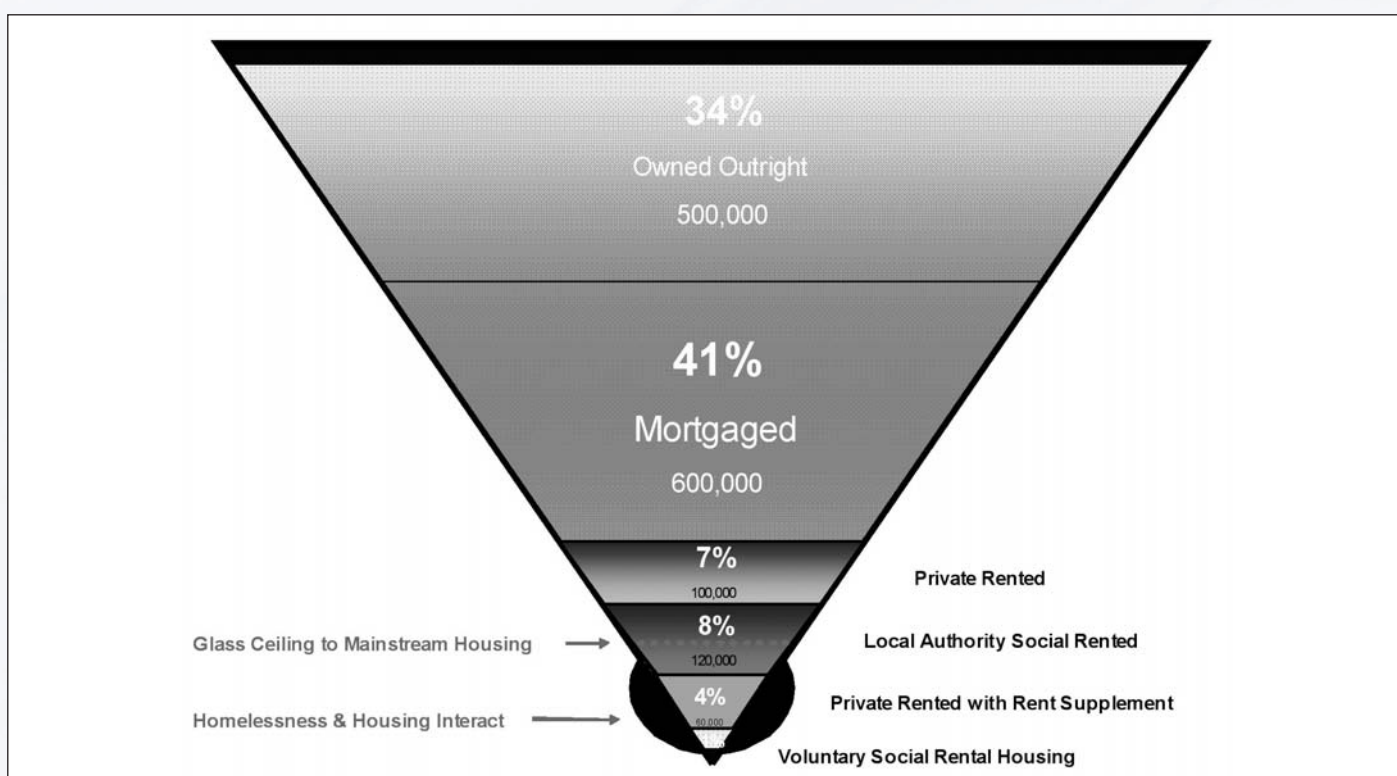


Figure 1: Housing and Homelessness in Context

Over the eight year period 2000 to 2007 the Department of Environment, Heritage & Local Government (DoEHLG), the Department of Health and Children, local housing authorities and voluntary organisations have invested approximately €570 million to addressing homelessness. This excludes capital funding.

Nevertheless, as Pillinger concludes in the recently published Homeless Pathways research: “It is when long-term accommodation is provided that it becomes possible to organise and meet appropriate support needs. The research has shown that pathways out of homelessness are blocked” (Pillinger, 2007: 67). Pillinger’s analysis of moving into and out of homelessness is further detailed in this volume.

Homeless dynamic case study

The ‘homeless system’ across Dublin’s four local authorities represents the most developed and substantial homeless initiative in the country. Extrapolating data from the last official audits of homelessness across Dublin for 2002 and 2005 and presentations of homeless households during and since those years provides a meso-level case study of this system (Figure 2 below).

2,560 households were reported as homeless in the 2002 count. In 2005 the number had reduced to 1,316 households of which 77 percent were single people, a ratio consistent with the previous count. 23 percent of these households were homeless for less than six months; 43 percent for more than three years. During the period of the case study and since there has been an average of approximately 1,800 new households presenting as homeless per annum. The net effect of the average entry into the ‘homeless system’ and the drop in number of households within the system has been an annual ‘graduation’ out of the homeless system of about 2,200 households per annum.

The destination of these households is of interest given that they are the product of much of the current national investment of approximately €90m per annum and represent the outcome of often years of effort on the part of the household themselves along with the services that have worked with them towards moving on.

Experience suggests that annually approximately 300 social rental units are allocated to these households from the housing available across both local housing authority and housing association providers. This is even when the local authorities, and Dublin City Council in particular, have quotas for lettings to households who have been homeless. Single person households, who are disproportionately represented in homelessness, are likely to be under-represented in this allocation given the configuration of social rental stock towards family units and a propensity to allocate the scarce resource that social housing represents accordingly. There are a percentage of households that will find their way to institutional care and others that return to a secure home. If the balance is c. 1,750 household and if approximately 80 percent of those are single person households then c. 1,400 single person households are looking to the private rented sector for a stable, secure, decent, affordable home.

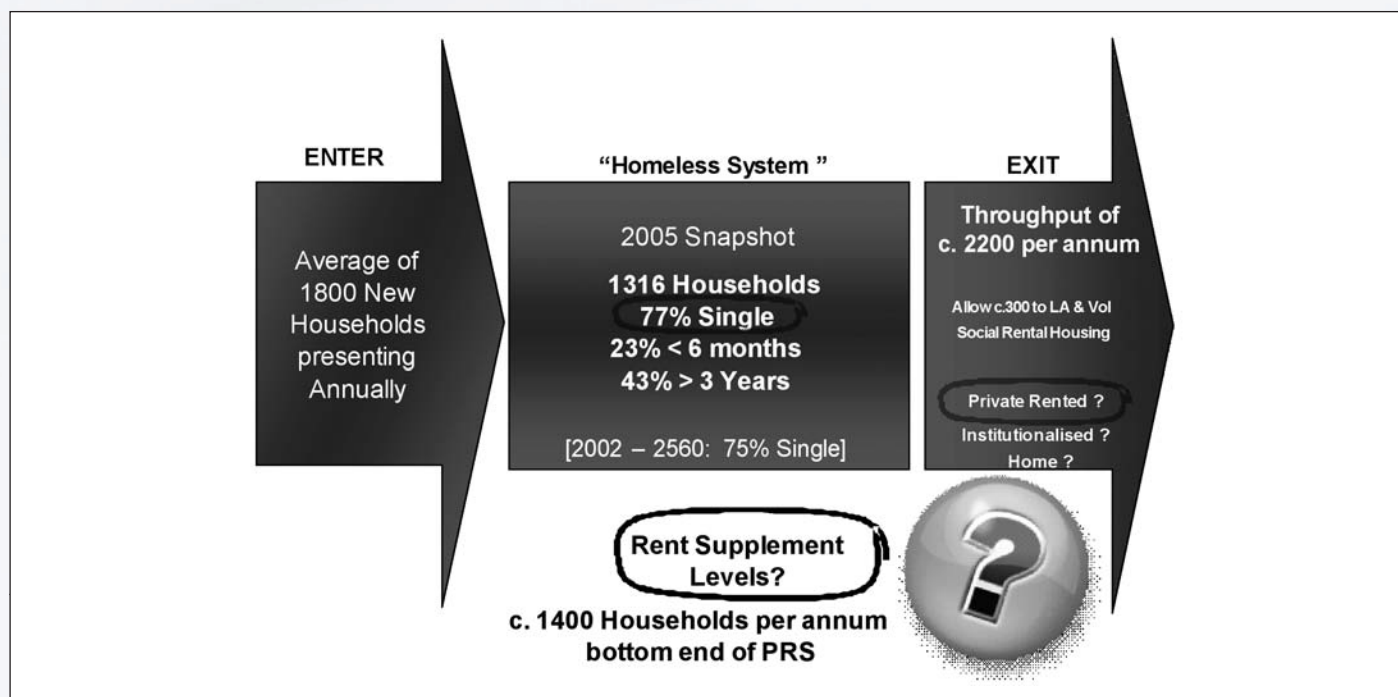


Figure 2: Extrapolation: “Homeless Dynamic - Dublin” by Household

The particular role of the private rented sector

The default position for move-on housing for the majority emerging from homelessness is the private rented sector. At the point of emerging from homelessness, people are likely to be dependent on income supports. *Counted in 2005* for example reported 2 percent of homeless households as being in employment. Consequently, the real value of the rent supplement available to households on a very limited income seeking accommodation in the private sector is critical. In Dublin, a single person household currently receives €120 per week against a typical rent of €200 per week for a reasonably decent, small one bedroomed unit.

This suggests that access to home for the majority of those graduating from homelessness requires the construction of forced households of individuals sharing decent accommodation on a long-term basis (with the consequent risks and management issues) or alternatively securing individual bed-sit accommodation at the bottom end of the market.

This gravitation to accommodation that in order to be affordable will not be decent or appropriate coincides with other limitations in the private rented sector. It is also unlikely to be secure, particularly given the likelihood that the needs represented in this constituency of households will require capacities for tolerance and management that landlords in the cottage industry that is the private rented sector in Ireland rarely possess. Those with advocates and supports are more likely to secure the prize of social rented housing from a local authority or housing association.

The private rented sector serves as the reservoir where the most vulnerable are dispersed, churning in a manner that masks the reality of their individual need and the extent of their collective need. Through a combination of market realities, life circumstances and personal needs, people leaving homelessness do not have a place to call home despite heavy investment in support whilst they are homeless and in preparing to move on to live in a home of their own. The accommodation on offer is, for the most part, unlikely to be acceptable to the vast majority as a long-term home.

Housing access

The valuable progress achieved by service users ready to move-on is compromised without the stability and security that is a prerequisite of their sustainable settlement. The effort and cost of providing homeless services is negated if they cannot transition out of homelessness and into home.

The Homeless Agency action plan for Dublin to 2010 (*A Key to the Door*) projects that at least 1,000 primarily single person households with support needs graduating from homelessness will require social rental housing that will have to be sourced in addition to hoped for social housing delivery over the life of the plan. This projection does not take cognisance of a range of housing supply and access issues presented in this chapter, or of the quality and sustainability issues already posited regarding the move-on already taken as given.

Some homeless service providers with competency in housing have therefore embarked on programmes to secure access to homes for those vulnerable to and emerging from homelessness. These efforts have both engaged available mechanisms and sought to innovate new vehicles for generating access to decent homes. They have involved mainstream and specialist housing providers drawn from across the statutory, voluntary and private sectors. They provide standard forms of housing: houses and apartments, either standalone individual units or in dispersed clusters or small-scale blocks. What are being delivered are homes that are differentiated simply by the fact that the tenant, according to their needs, is likely to benefit from enhanced housing and support services.

Local authority provision

The primary providers of social rental options in Ireland are local housing authorities working in conjunction with the DoEHLG. They have also, on a rather localised, individualised and ad hoc fashion, been providers of move-on housing from homeless services. A number of pressures now undermine this:

- Homeless services have expanded quite considerably increasing the demand for move-on to more appropriate long-term, affordable housing.
- The public sector housing stock in Ireland has tended to be configured for families rather than single person households and has therefore not been able to cater for the demand profile emerging from homeless services.
- This coincided with market pressures associated with resource rich, investor driven demand creating a very uneven playing field.
- It has also coincided with an ongoing attrition of public housing stock through the tenant purchase scheme which has been particularly effective at transferring the best quality housing in the highest demand areas out of the available rental stock. A key argument for tenant purchase has been that very little of the public rental housing comes available for letting. However, if only 3 percent of the more than 330,000 publicly provided housing units came available each year it would provide 10,000 homes per annum. Two thirds of that publicly provided housing has been sold off at substantial discount.

The average annual addition to national local authority rental stock over a 10 year period to the mid-2,000s was 3,932. Average annual sales to tenants during the same period meant an annual attrition of 1,619 on that gain leaving a net annual gain nationally of 2,313 (Drudy & Punch 2005).

Local authority housing tends to be politicised in its use, supply and retention. Analysis of the UK experience suggests that “councillors have often regarded housing as devoid of mystique, a matter of common sense, and of particular immediacy to the individual households and communities comprising their own electoral powerbase” (Cole & Furbey 1994: 122). Arguably the same inclination to stray beyond policy making is a feature of the Irish local governmental landscape. Risk management in the allocation of public housing, for example, tends to operate from the premise that historical form, be it real or perceived, is the best predictor of future behaviour. So even when quotas for allocations to homeless households exist they do not tend to be met.

In fairness to local authorities; there are legacy issues they contend with:

- The rental system and income is divorced from the housing provided;
- Their capital funding system has been designed to operate on a build – neglect – demolish cycle;
- They have not been resourced to manage effectively;
- The stock has been privatised in a manner that means the most problematic housing and tenants are left to them and concentrated in particular geographical areas.

Their legacy therefore is the need to re-engineer both the housing and the social and economic fabric of substantial swathes of central areas of main urban areas, the same areas that represent greatest demand from homeless services. Regeneration programmes soak up huge resources addressing ingrained and valid local issues. The effort is to rebalance the profile of an area by leveraging in non-social tenures. This entails the effective exclusion of those who have been homeless from local authority housing development programmes.

Otherwise direct local authority social housing development programmes are being replaced by private sector provision under Part V ‘20 percent Social & Affordable’ housing requirements of the Planning and Development Act, 2000.

Housing association provision

Housing Associations tended to be the primary provider of ‘special needs’ housing. Of c. 20,000 units provided by housing associations nationally to date approximately 1,400 were for homelessness, mainly as hostel beds and transitional/temporary forms of accommodation.

Providing a home negates the mobility and insecurity associated with navigating temporary accommodations in

the homeless system and transfers the onus to service providers to be the ones who are mobile and flexible. Within the small pool of housing associations actively addressing homelessness the effort to move towards a 'housing first' approach in recent years has gained some traction in spite of a range of challenges.

NIMBY (Not In My BackYard) resistance by local communities has long been the experience of social housing development. NOTE (Not Over There Either) resistance is the more pronounced resistance that meets projects perceived as representing homelessness.

Local authority and public support are ultimately required to realise a project and tends to be very difficult to secure. It is relatively easy to secure support for the principle of a project. The problem is when the project has a specific address and location requiring specific support! A reality for homeless services is that their objectives are admired and supported from afar. (It is important, however, to acknowledge many cases of very affirming and active support of local communities and officials).

A particularly problematic issue is revenue funding for support services associated with housing provision. Once someone is housed they are no longer homeless. Revenue funding available from the local authority and the DoEHLG is intended for the provision of accommodation whilst homeless. Revenue funding of the Health Services Executive (HSE) is intended for care to the person whilst homeless. There have been some initiatives to direct some homeless funding into supporting people in their home but these tend to be predicated on the service being a time-limited commitment of visiting support independent of the housing management. It is directed at the individual without reference to the context and community within which they live. Housing providers understand substantive tenancy sustainment as addressing the capacity of tenants to engage and sustain their tenancies through the day in, day out rights, responsibilities, trials and tribulations as members of a household and community and as a neighbour as well as an individual. These initiatives also assume that mainstream community care services are available and effective. It is however often the norm that totally predictable situations have to degenerate into a crisis before care services intervene. By then there tends to be no alternative beyond the institutionalisation of the tenant. Even established supported housing providers with the capacity to provide intensive housing management along with well developed relationships with community care services struggle to secure adequate interventions.

Social housing development as an enterprise has become increasingly involved. Procurement and contractual requirements are such that the technical aspects of development increasingly dictate the housing association's activities and priorities. Housing associations have their origins in responding to the housing and support needs of people and communities but the day of local 'social working housing providers' seems to be a thing of the past.

Housing associations tend to have a strong partnership ethos and those with a competency in homelessness increasingly work in conjunction with bigger, generalist associations with more substantial development programmes. However the homelessness component is two-edged; depending on circumstances representing either a political/planning risk or adding value to the proposed scheme in terms of skills and tenant mix.

Housing associations in particular have been priced out of main urban areas with very restrictive capital funding limits (as little as half the level available to local authorities!) in a ferociously competitive property market. Social housing programmes have been migrating out of urban areas into smaller town lands and rural hinterlands, and along with them the possibility of partnerships and homeless related allocations.

Like Local Authorities, Housing Association housing programmes are increasingly Part V based. A critical immediate issue is the pent up commitments on Part V delivering over 2008 into 2009. It has caused a stall on social housing funding approvals. This has halted the momentum built up over recent years in housing association and local authority development programmes. In Dublin for example, this was coinciding with delivering the required move-on to match the current homeless action plan to 2010. The opportunity for social housing developers to avail of the vastly improved market conditions has been plundered. This momentum will take years to recover.

Part V provision

Part V and the Rental Accommodation Scheme (RAS) represent two particularly significant social housing delivery innovations promoted over recent years and require consideration vis a vis homelessness. They are both high profile, high potential mechanisms that need to be seen to work. Local authorities have therefore tended to be very risk adverse in their approach to both Part V and RAS.

Part V was subject to vigorous resistance and litigation as developers and the public in general have a preference for keeping their estates 'clean' of Part V. There is in effect a graduated 'Part V Clean Development Rating' looking something like Figure 3 reflecting these preferences in descending order of desirability.

Form of Provision	Rating
Part V Exempt	A.1
Cash in Lieu of Part V	A.2
Off-site Provision	B.1
Affordable Housing	B.2
Specialist: Elderly	C.1
General: Housing Association	C.2
Specialist: Physical Disability	D.1
General Local Authority	D.2
Specialist: Learning Disability	E.1
Specialist: Mental Health	E.2
Homeless: multiple needs	F

Figure 3: "Part V Clean" Development Rating

The capacity of local authorities to administer and control Part V has been an issue. It would not have been unusual, for example, for a local authority official to field negotiations with very highly resourced technical representatives of developers worth hundreds of millions. If a robust defence involving detailed tracking and ongoing negotiation throughout the development process is not mounted the final result can often be an effective lock-out of social housing due to high capital costs or indeed high revenue costs in the form of service charges that are not sustainable for either low income social housing providers or tenants.

With experience some local authorities have become quite sophisticated in addressing and managing the supply of Part V. Also the principle of Part V has become established as a fact of life.

Part V applied

With supply becoming established the issue becomes the use of housing secured via Part V. Initially most local authorities were happy for developers to select their own Part V partners. Selections were made mainly according to the 'Part V Clean Rating System' as above! Increasingly local authorities have been inclined to be more directive in this and reserve the right to allocate Part V as it sees fit. They tend to reserve to themselves the first choice of units according to their convenience or preference. This might mean for example that developments with large volumes of apartments and service charges will be allocated to larger, generalist housing associations whilst smaller, more manageable developments (and particularly houses without service charges) will be retained by the local authority. Whilst the policy may be practically driven it effectively locks out homeless providers.

This is ironic given the positive opportunity that Part V represents. Housing managed by a professional housing manager and support provider along with tenants investing in their accommodation as their long-term home often stands out against surrounding housing where individual units were for the most part bought by multiple investors and rented on to a far more transient population. Dispersed absentee ownership also compounds deficiencies in the control and accountability of private management companies and the long-term quality of the buildings. Professional housing associations offer better stewardship.

Local authorities have tended to promote 'pepper potting' as the preferred form of provision in Part V. This involves taking units scattered throughout a development in order to avoid ghettoisation and promote integration. Pepper potting does have its merits and can be preferable but it is by no means a panacea and should not be promoted as the only option. Indeed Norris (2004) noted in her recommendation on the location of social-rental dwellings in mixed-tenure estates that clustering held no disadvantages against pepper potting and that clustering social rental dwellings has some significant advantages. Ghettoisation is a product of a range of variables including scale, density (particularly of children), design, marginal location and facilities and socio-economic complexion of the tenant body. However, a clustering of a number of social rental units together with a balance of needs within a stand-alone block can have many positive attributes: the tenants share a landlord and service level; tolerance, caring and community can be more easily promoted amongst a group of tenants who have invested heavily in both their independent living skills and the stability they have achieved and who deeply value their home and neighbourhood; issues if they do emerge are containable and therefore recoverable; service costs benefit from critical mass which allows a more targeted investment in supports and community development. Experience validates that a cluster of social rental housing can function very successfully and discretely and indeed serve as a model of how housing should be managed and how community can be nurtured and integration realised.

Social versus affordable use

Part V is now critical to urban social housing provision. At this stage it accounts for about 20 percent of social and affordable housing provision nationally. It has been taking up slack in the fall off in traditional social housing provision in key urban centres. Unfortunately there is a problem with the allocation of actual and pipeline Part V to social rental housing, with many of the significant urban authorities devoid of any, and the prognosis for the future is poor. The preferences of elected representatives have tended to reflect the instincts of their electorate, translating into a clear policy bias towards affordable housing for sale rather than social housing for rental.

By definition affordable purchase housing and social rental housing serve different constituencies. Part V provides housing at a discount to the market but still requires a substantial enough income to service a still substantial mortgage. Affordable housing schemes service households with incomes from around €40,000 per annum. Social rental housing has tended to service households with incomes less than €20,000. (The Affordable Homes Partnership in particular has been developing options for bridging the gap for households between those two income profiles with various hybrid purchase and rental schemes.)

Seventy percent of more recently proposed Part Vs are earmarked for affordable provision, up from 63 percent of those currently in progress (Quarter 3, 2007 Housing Statistics, DoEHLG, Dec. 2007). While demand for social housing is relatively well defined, the demand from homelessness is less well defined reflecting the state's instinct is to construct homelessness as a status at a point in time rather than a dynamic with clear pathways in and out. The demand for affordable housing has been more ambivalent and more so with the emergence of more favourable conditions for buyers in the housing market.

Part V delivery to date has been to affordable housing by a margin of two to one. This is partially explained by the factors driving regeneration/social re-engineering programmes as previously noted. Unfortunately Part V is not servicing social rental housing in many high demand areas and generally does not service those emerging from homelessness in any event. Even with peak Part V delivery over 2008/2009 this is unlikely to shift.

Rental Accommodation Scheme provision

The Rental Accommodation Scheme (RAS) was established in 2004 to reconstruct rent supplement income support into a housing supply mechanism. The transfer of households on long-term rent supplement into RAS gives local housing authorities the opportunity to manage the pooled supplement to leverage more and better quality accommodation.

RAS has required local authorities to assess the transferring households and accommodation. This process has revealed the reality of the state-sponsored conditions many people have been living in and the level of vulnerability concentrated in the constituency of households on rent supplement. They incorporate many who are vulnerable to homelessness or who have graduated from homelessness into the only housing option available to them. RAS administrators have estimated that, depending on the area, between 10 percent and 40 percent of the households they are assessing present significant support needs as well as require re-housing. There are approximately 30,000 households eligible for RAS so that equates to anything from 3,000 to 12,000 households requiring enhanced housing management and support. If this formula is applied to the 60,000 households on rent supplement those figures double.

A significant effect of RAS has been to start gradually increasing standards in the bottom of the private rented sector. However the volume of substandard accommodation in that market outstrips the capacity of RAS to present alternatives. RAS has opened up the can of worms that is the bottom/welfare end of the private rented sector and it will take years to work through given the scale of the challenge. In the meantime RAS faces significant disconnect between the need it is charged with addressing and its capacity to service it.

RAS applied

Although RAS has had significant political impetus since its inception, it has been struggling to deliver. There is insufficient money in the RAS system and yet it seems expected to singularly address key issues in housing need, supply and quality. RAS is ultimately a transfer of rent allowance to the local authority. The transfer of a single person household with a rent allowance of little more than €500 per month will be expected to service the cost of more adequate accommodation at an additional cost of at least €300 or €400 per month. If the household is a transfer out of a homeless transition programme capital funded by the DoEHLG, and therefore subject to what is referred to as an 'economic rent', the rent allowance shortfall to RAS will be €600 to €800 per month. The combination of shortfalls towards meeting the real cost of decent housing (increasingly including substantial service charges for apartments) and the lack of supply into RAS from the private sector has meant that RAS has looked to the social rental sector for help both in terms of housing supply and support services. Ironically within this RAS is looking to the capacity of supported housing providers to provide enhanced management services to RAS even though allocations into RAS by homeless services are increasingly difficult to secure. Rather than supplying additional housing options for those emerging from homelessness RAS has been pulling from the social rental pot of capacity to address the issues and needs it has been encountering. The positive side to RAS has been the opportunity to experiment with housing delivery tools across tenures, capital and current funding mixes, leasehold mechanisms and partnerships between local authorities and other social housing and support service providers and the private sector. These innovations mean an investment in doing things for the first time; creating templates, mechanisms and learning.

In order to establish its credibility with landlords and developers, RAS has had to be risk adverse. In spite of this though there was a keen interest in the DoEHLG and a number of key local authorities to engage the learning and expertise of supported housing providers resulting in a number of pilot RAS projects providing move-on from homeless services. Over the two years of the pilots there have been three developments. Firstly, the scale of the challenge facing RAS in its own right, both in terms of housing and support needs has crystallised. Secondly, the anticipated momentum in supply has not materialised and thirdly, the willingness of RAS to develop a homeless strand to its programme has created an additional weight of demand and expectation on RAS that it cannot carry. The initial willingness of RAS to extend itself in this direction has contracted under the weight of these circumstances.

Leveraging through managing partnerships

A key means of providing housing access to homeless households is by leveraging access into housing from mainstream housing suppliers in return for enhanced service. The small caucus of service providers that work both in homelessness and housing management represent a distinctive competency that can be traded with housing suppliers in return for influence on allocation to their housing. For Focus Ireland, for example, this strand represents 50 percent of our current housing access initiative (the other 50 percent being our own building and purchase programmes). Our priority is the quality, security and application of the housing to those emerging from, or vulnerable to, homelessness, rather than its ownership. To date RAS and 'recycled Part V' (meaning Part V taken and retained by the local authority or housing association but allocated back out to us for management) have been the main deliverers. We also have a number of partnerships with housing associations.

There are three main points to note. Firstly it is a derived supply and is subject to the range of challenges and issues noted for the various supply chains examined above including migration of housing programmes and the increasing primacy of Part V.

Secondly our control and influence is at arms' length and delivery onto us as a third party is always more tenuous. We have for example been excluded even though our housing provider partner wanted us to take part of their scheme. In other cases the level of influence we exercise on who the housing we manage goes to is not what we had anticipated.

Thirdly, the housing provider who owns the property requires the limited rent to service their property costs and future liabilities and there is not enough cash for both the owner and the enhanced service provider to draw from. This is more so the case with the emergence of apartments and service charge liabilities. At least with our own housing we can retain a component of the rent towards our own management cost. In the absence of a distinct revenue stream to support enhanced housing management in the community all managed units represent an even greater cost to us.

Market purchase for social rental housing

The capital funding schemes can be applied to the purchase of housing directly from the market. This option is not ideal in terms of relative value for money against Part V or building by a housing association, both of which represent a discount against market values. However given the difficulties in securing access to move-on from homelessness we did secure support in principle from a number of urban housing authorities to undertake a market purchase programme. The experience of this has been challenging to put it mildly!

Our programme was undertaken against the backdrop of a ridiculously competitive housing market. Values escalated without logic and we had to be particularly price sensitive given the amount of capital funding available under the social rental schemes.

Administration

The administrative systems around capital funding are not configured to support performance in the market place. A housing association develops a proposal for a scheme in consultation with the local housing authority, who undertake their own appraisals in order to decide if they will sponsor it onto the DoEHLG for funding approval. Any application for funding thereafter is administered between various units of the DoEHLG in different parts of the country and various different sections within the local authority. Securing a decision on funding with so many parties involved can be very prolonged and difficult. Actually getting approved funding released also often tends to be a very arduous experience leaving plenty of room to kill off any purchase proposal that might have survived the process of getting a funding approval. (In fairness, there is a significant effort underway to streamline the capital funding appraisal system. However it has coincided with a significant elevation in the standards applied in the procurement and contracting of consultants and works and envisages an increasing devolution to local housing authorities and their gearing up accordingly. It will take sometime before the system will function in a more streamlined manner.)

We created our own bridging finance arrangements which meant that we regularly purchased properties at risk until such time that we could retrospectively pursue statutory funding approval.

Securing support

Decisions around supporting a project can be a rather nebulous affair. Translating a support in principle for a programme for securing housing within a particular local authority area to a particular scheme tends to be a challenge. The only areas where capital funding limits made purchase viable were areas with existing concentrations of social housing. Policies effectively precluded any further social housing provision in those areas as part of social re-engineering efforts.

Even when pockets are found where this might be navigated around it tends not to happen due to the fact that the local housing authority will inevitably have some other actual or potential scheme in the vicinity and an additional scheme would present a complicating factor for that. Housing associations can be viewed suspiciously by public representatives given the political primacy of purchase over rental and the lack of a 'right to buy' option for housing association tenants. Regardless, proposals related to homelessness tend to be even more politically sensitive. Within the local government system a pragmatic approach is required in navigating potential sensitivities before they become real sensitivities.

The greatest challenge though has been securing adequate quality accommodation at a reasonable price and within the very low capital funding limits available to us through the funding schemes. We have inevitably ended up buying second-hand properties requiring refurbishment: an intensive process in terms of management, time and risk.

Recent developments

Towards the end of 2006 the housing market began to stall, creating a 'stasis problem'. It has been, ironically, increasingly difficult to justify value for money in a market where prices are falling, even when securing substantial discounts. This is compounded by the length of time between undertaking a valuation and the funding application being processed through to a decision. Also the credibility gap between vendor expectations and value has been until recently, remarkably resilient. This has coincided with a number of factors meaning a shift in investment strategy on the part of the DoEHLG.

- There has been, over a number of years, a significant drive to gear up housing supply capacity across the social rental sector. A housing development programme requires a run-in of years and once up and running is dependent on momentum. Significant programmes from local authority and housing associations were rolling towards peak delivery over the coming two years.
- There has been a significant overhang from 2007 commitments when the brakes were put on capital funding well before the end of the year and yet spending commitments were locked in.
- There was also significant publicity and questioning about the scale and sense of a programme that entailed local authorities buying back its own stock from the market at a significant premium.
- Commitments have been made to a huge programme of regenerations across Limerick City.
- Most significant of all is the scale of Part V commitments coming together. 2008 will represent peak Part V supply across the country. Part V represents often hard-won, and always binding commitments which are likely to dictate how national social housing programme budgets are prioritised over the next 18 months. The cost to the momentum of social housing programmes for years to come is huge.

The end result is a significant bubble of capital funding commitments that mean hard choices are being made. In this context a market purchase programme comes off the table at the very time when it is, at last, a buyer's market. Within it goes a hugely significant resource to securing move-on options for households emerging from homelessness in the very places where alternatives are most limited.

The way ahead

So, the scenario of providing housing options for those emerging from homelessness is not positive. There is very limited access to a depleted, residualised social rental stock, particularly for the profile of largely single person households. The majority of these gravitate to the bottom end of the private rented sector on a very restricted rent supplement. RAS as an initiative is struggling under the weight of demand and expectation. The

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traditional mechanism for bridging the provision gap by a very small number of voluntary housing associations dedicated to homelessness undertaking housing development programmes is under duress: the traditional sources for development opportunities on donated or low cost sites have dried up and alternatives are difficult to come by given the combination of market, administrative, funding and political issues. Part V does not deliver to the profile of household represented in homelessness. Partnership programmes are derived and reflect the whole range of challenges of each delivery mechanism along with the complication of being at arms' length. Purchase programmes from the market cannot compete against the value for money benchmarks of Part V and direct build.

The picture is bleak and the implications for the investment by customers, policy makers, funders and service providers into homelessness are stark. We have to look ahead. On a macro level there are issues about what type of society we want and the role of our housing system in that. There are issues about social housing and how it is used, configured and valued as per NESCs *Housing in Ireland – Performance and Policy* (2004). There are issues regarding the role of the private rented sector as a housing safety net. The issue of how it can be properly equipped in this role requires a critical appraisal of how it is financed and managed. The roles of both the private and social sectors in driving the development of a larger, more broadly based, more professional and viable rental sector needs hard looking at. Focus Ireland have recently published *Rental Systems in Ireland – the Case for Change* as a contribution to interrogating this issue.

Below that there are practical issues regarding the rent supplement system that require urgent review but with an eye to a wider vision. The private rented sector will be the most likely housing option servicing the homeless system for some time to come. The issues of quality, affordability and security require much more work. RAS is an important applied vehicle in the experiment of addressing these issues and needs the practical and political resources to support its delivery. This means being equipped to operate outside traditional social housing areas and to function with adequate management and supports for the needs it holds.

Social rental housing, in all its guises, needs to be allocated and resourced in a manner that ensures those who are vulnerable are not locked out. Providers and tenants need access to the distinctive competency capable of engaging and reconciling the needs of the individual and the community. It's neither a housing nor a homeless based competency. It is in the applied and practical combination of the two that the competency to support the establishment and sustainment of a tenancy and a home is found.

Targeted investment in social rental housing is critical. Former Taoiseach, Garret Fitzgerald wrote to the Irish Times in September 2006 advocating a planned national housing investment strategy switch towards social housing as a means of weathering a financial downturn. Social housing programmes are now being pulled back relative to the momentum accrued. In the context of a more conservative social housing programme homelessness should be given a priority status. This is both to extract the value of the huge investment into homelessness and to ensure that vulnerable households requiring a decent home have access to one. Capital funding approvals could be conditional on allocations to homelessness or partnerships with appropriate providers. Some of the Towards 2016 commitment for the State to provide an additional 3,000 sites to housing associations could be targeted towards servicing homelessness. A specific capital housing programme could be earmarked for initiatives addressing the housing need of those vulnerable to or emerging from homelessness.

The resource that is the homeless system needs to function properly with a clear pathway to a decent home. Local Authorities needs to account for the dynamics into and out of homelessness with a more strategic approach to housing action planning incorporating all the supply and access options available. In particular they must assert their responsibility and authority in directing what Part V supplies and how it is applied to local needs. Local authorities must also enable approved social housing providers to provide access to vulnerable households requiring access to a home, and support the work of more specialist providers.

One way of incentivising allocations is to provide, on a pilot basis and as a means of modelling and testing a more general intensive housing management mechanism for application in supporting RAS and Part V, a revenue funding package dedicated to those leaving homeless services.

If the association with homelessness is an impediment to more specialist housing providers being able to secure

housing, and yet they offer the competency to do the job, how can they be offered cover and support? This might be through direct allocations of Part V, a slice of a development programme or a 'recycling' on of Part V that is retained by the housing provider but passed on to the specialist provider for letting and management.

There are assumptions that need to be challenged in practice: Can more specialist providers be viewed as an additional resource rather than a risk or a threat? Can we continue to help, proving that the likes of Part V and RAS often work even better when those for whom it provides a home have invested much more than most in securing that home, and where they benefit from a professional supported housing landlord?

Conclusion

Access to a home is a prerequisite to any effort to address homelessness. This review has held up a mirror to the practicalities of housing access to some of the most vulnerable in our society. What is disturbing within that is that they are already the beneficiaries of a very concerted and significant investment and that still does not qualify them for acceptance. The mirror of their experience reflects issues around our collective capacity and willingness to address homelessness.

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DOMESTIC VIOLENCE AND HOMELESSNESS: A PRACTITIONER'S PERSPECTIVE

SHARON COSGROVE

Introduction

As a new arrival – a mere novice to the homelessness and domestic violence sectors – being asked to write a chapter is both an opportunity and a challenge. It is an opportunity for me to reflect on what I have seen in my 16 months directing an organisation that specialises in providing housing and support for women and children who are out of home due to domestic violence. And it is a challenge to articulate a full and accurate picture of the complex policy environment in which I am now working!

The recent news media coverage of high profile court cases of partner/marital homicide followed by debate and outrage at short prison sentences on the likes of the Joe Duffy radio show raises public concern about gender-based domestic violence. But it seems rare that I hear specifically about homelessness and domestic violence in the media. Maybe we don't automatically make the connection between these two social issues or maybe domestic violence is not an attractive story. Perhaps, as a society, we don't really want to be reminded that women (in the main) and children have had to leave their homes to flee for their lives, uproot themselves and go to family, friends or to a refuge for safety, security and support. Perhaps it is very uncomfortable for us to think that children had to leave their toys, their friends, their school and their home because they were unsafe and living in fear.

Within the homelessness sector, at most meetings that I have attended over the last 16 months, I have listened to and participated in discussions about the more prominent issues for homeless providers:

- *How can we eliminate street homelessness?*
- *How can we ensure throughput from emergency to transitional to permanent housing?*
- *How can we meet the long-term complex needs of homeless persons with addictions and mental illness?*
- *How can homeless service providers provide or access the wide range of supports and services to meet the multiple needs of our service users?*

We focus on the questions and the current solutions including the care and case management approach, maximising occupancy rates and testing new approaches like 'tenancy sustainment'.

These discussions echo those that are going on in meetings that I attend with my colleagues in domestic violence services who are working with women in refuges, on helplines or in support services. Domestic violence services are also struggling to meet the complex needs of women. Addiction or mental illness may be a woman's 'primary need' and domestic violence is either hidden or 'secondary'. My colleagues in the sector are experiencing particular difficulties in securing move-on or permanent accommodation after refuge, due to eligibility restrictions for women without residency status and lengthy family court system proceedings for joint home owners. Ongoing separation proceedings prohibit a person from getting onto a local authority housing or homeless list. Therefore the duration of stay in refuges appears to be lengthening (a.k.a. 'silting up') and throughput is an issue for domestic violence and homeless services alike.

So when I reflect on homelessness due to domestic violence, I see a complex web of problems that needs a complex interwoven web of policy responses. These involve policy responses in housing, homelessness, health, children's services, family law, justice, policing, residency, and so on. And that's not easy!

In this essay I will focus on particular aspects of homelessness due to domestic violence and will make some recommendations for policy responses. Firstly, I will explore the link between homelessness and domestic violence and define the scope of the problem. Secondly, I will look at the responses and services provided to women and children who experience domestic violence. And finally, I will look at current national policy responses, both at government level and at local level through local authorities, the Health Services Executive (HSE) and voluntary housing/homeless organisations, and make recommendations for change.

Homelessness due to domestic violence – how big is the problem and do we have a coherent policy response?

I think that the starting point is to establish what domestic violence is and to what extent it impacts on homelessness or housing need. Domestic violence is acknowledged in Irish government policy and the accepted definition in use in Ireland is:

"The use of physical or emotional force or threat of physical force, including sexual violence, in close adult relationships. This includes violence perpetrated by spouse, partner, son, daughter or any other person who is a close blood relation to the victim" (Report of the Task Force on Domestic Violence 1997: 27)

International studies have found that approximately one in five women reported having been subjected to some form of violence, including mental cruelty, actual physical violence, threats of physical violence, sexual violence and damage to pets, property and other items (Kelleher & O'Connor 1995). A new national office for domestic violence in Ireland, Cosc, states that one in five girls in Ireland experience sexual abuse in childhood, 42 percent of women and 28 percent of men experience some form of sexual assault in their lifetime, and 15 percent of women and 6 percent of men have experienced severe abusive behaviour from a partner.

The UK statistics from the UK Home Office state that domestic violence will affect one in four women and one in six men in their lifetime and that 77 percent of victims of domestic violence are women (Nicholas, Kershaw & Walker 2007). The UNHCR, the Declaration on the Elimination of Violence against Women (1993) states that *'While women, men, boys and girls can be victims of gender-based violence, women and girls are the main victims'*. As the Director of Sonas Housing Association, a women's domestic violence housing organisation, violence against women is my particular area of interest and is therefore reflected in this essay.

The link between domestic violence and homelessness is clear. In a report on domestic violence in Ireland, Kearns, Coen and Canavan (2008) found that 55 percent of victims of domestic violence vacated the family home. Other studies have provided evidence that the majority of women who do not vacate the home (88 percent) do not leave violent partners because they have nowhere to go and because of the lack of affordable accommodation (Making the Links, Kelleher & Associates & O'Connor 1995). These figures highlight the extent of the housing need for women in situations of domestic violence and the reality of having to stay in a violent relationship because of problems of access to housing.

There has not, however, been a national study that quantitatively examines the impact of domestic violence on homelessness in Ireland. International studies suggest that between 20-40 percent of homeless people are without a home due to domestic violence (Reeve, Goudie & Casey 2007 ACLU 2004). In 2007, a working group of the Homeless Agency looked at a population of 36-40 homeless women with multiple needs in Dublin and found that two thirds had drug related support needs, one third had alcohol related support needs and over one third had experienced domestic violence. This is a small group, however, and is not statistically valid.

In dealings with local authorities around the country, Sonas and our local partners are constantly asked to present the 'business case' and the 'evidence base' for homeless services for women and children to the funding bodies (the local authority and the HSE). While we reference the local domestic violence service's statistics and the local authority's homeless list, we encounter inconsistencies between local authorities in how they assess

homelessness. In some cases domestic violence is not even considered as a possible cause! This presumably leaves a cohort of women and children whose needs are not being captured and are not being met.

The way we currently assess causes of homelessness does not accurately capture domestic violence as a cause. Ireland's levels of domestic violence against women are comparable to levels in the UK, but we are not necessarily seeing comparable levels of homelessness due to domestic violence against women. This may be due to the way in which we assess the cause of the homelessness when someone presents as homeless. When I contacted the Homeless Persons Unit last year to see if I could plan ahead and gauge the likely demand for transitional housing services for Sonas, it was impossible to identify the extent of homelessness due to domestic violence. The Homeless Persons Unit suggested that it might be hidden in other listed causes such as 'family violence', 'anti-social behaviour' and 'family breakdown'.

If we are not capturing the extent of the problem accurately or identifying the causes properly, how can we properly respond to the needs of women who are homeless due to domestic violence? In order to put in place the appropriate range of services to meet a woman's needs and those of her children, we as homeless service providers need a really good analysis of the problem. This includes knowing how many victims of domestic violence are 'on the street', how many are 'houseless' and how many are in 'insecure accommodation'. Only then can we provide appropriate responses by focusing on the needs of the individual responding to those. What are their individual needs? Accommodation? Specialist domestic violence support? Legal advice? Protection and safety planning? Addiction? Mental health services? Parenting supports?

So what are the current responses to homelessness due to domestic violence?

There are a number of responses to homelessness due to domestic violence. Some, including Sonas, address accommodation and support needs, whilst others are purely an accommodation response. Agencies of the state, namely the local authorities and the HSE, play a crucial role by financially supporting these responses and enacting policies and practices that directly impact the responses.

The Refuge Response

According to Watson and Parsons (2005), 55 percent of victims of domestic violence vacated the family home, with the vast majority going to family and friends. Of those that did not turn to a social or family network, 5 percent went to a refuge, 2 percent to a homeless hostel and 5 percent lived on the streets. Refuge is a specialist response where women are offered qualified counselling and practical support, either in-house or by arrangement, and the refuge staff work with the women to support them in addressing multiple problems related to health, financial survival, safety outside the home and the well-being of their children. In 2006, 1,952 women and 2,985 children were accommodated in refuges (National Networks of Women's Refuges and Support Services 2007). I suggest that the women in refuges are those with very few resources and ensuring their own and their children's physical safety is paramount.

Each year a significant number of women and children cannot be accommodated in refuges due to lack of space. In 2004, the three refuges in the Eastern region refused twice as many women as they accommodated; 1,144 women were refused refuge. Anecdotally, refuge managers are reporting longer lengths of stay in refuges due to lack of move-on options into social housing, transitional housing or into the private rented sector – these sometimes being due to lack of provision and sometimes due to financial, social housing or homeless eligibility criteria of the local authorities.

Not only is the number of refuge spaces unable to meet current demands, but also the level of provision falls short of international recommendations of 1.7 bedspaces for every 10,000 population. The Dublin area would need to have 201 refuge bedspaces to meet current population levels. We currently, however, have only 31 rooms and a further 12 under construction. By 2021, based on population projections, we will need 245 refuge bedspaces. Who is going to lead the development of this level of refuge provision? We need to urgently develop a timeframed action plan with the local authorities, the DoEHLG, the HSE and the voluntary providers to make this happen, particularly because current refuge development at Blanchardstown tells us that the lead-in time for such a facility may be up to 12 years.

The need for the Blanchardstown refuge was identified in the government's 1997 Taskforce Report. But this project only went on site in 2008 and is due for completion in 2009. If we look at the timescales and milestones from 1997 onwards, it took five years to include it in the Fingal Local Area Action Strategy, six years for the local authority to identify and agree the site, and 10 months to get post tender approval for the capital grant! Then, having received approval on the capital grant towards the accommodation units, we were faced with a shortfall on the communal building.

For me, the Blanchardstown Refuge highlights one of the main difficulties with refuge provision: it is left almost entirely to the voluntary sector to advocate and provide for development and funding. From its inception, this project has had cross-party political support, yet despite being identified by the government as a needed facility, no government agency was given lead responsibility for delivery of the project and agencies were not required to work together to ensure its delivery. The grant schemes in the DoEHLG did not take account of the communal building that is needed in a refuge for support work with women and group work with children. It was only due to the help of key individuals in the HSE, Fingal and the DoEHLG that the refuge finally received funding; it is due to open in 2009.

Refuge provision should not be dependent on 'key individuals'. There needs to be 'whole agency' commitment between health, local government and the voluntary sector to work in partnership to deliver these complex projects. There should be sanctions for delays and accountability to government. Refuge development does not neatly fit into homeless or housing (capital or revenue) funding streams. So creative solutions must be applied by funding bodies to 'enable' the provision by the voluntary sector. This enabling role, in my opinion, needs to be clearly and formally stated in government policy and be reflected in homeless policy and domestic violence policy.

Once the refuge is operational complex and incoherent policies continue to cause problems in relation to refuge services. Meeting the complex range of needs of people with addictions and mental health issues (which may have been caused by domestic violence) relies on accessing specialist services including social workers, addiction services and mental health services. For refuge workers, meeting these needs requires a quick response from addiction and mental health services and ideally to have them provided in the safety of the refuge itself. This, however, is a challenge for health policymakers and for those managing local services in the HSE.

Another challenge for refuges is the increasing number of non-Irish nationals availing of refuge provision. Refuges need to ensure that their services are accessible to all, are culturally appropriate and that non-Irish national women get the same quality service as Irish nationals and native English speakers. Accommodating non-Irish nationals who do not have residency status impacts on throughput because these women may have few, if any, move-on housing options. This results in less bedspace and consequently, more women being turned away.

B&Bs and hostels

Families who are not accessing refuges, either because of a lack of space or because of the age of their children, must turn to alternate options for emergency accommodation. One study suggests that 12 percent go to B&Bs or hotels and 2 percent end up in homeless hostels (Moore 1994). Not only do hostels and bed and breakfast establishments not have specialist domestic violence support services, but also in some cases these facilities may be exposing victims of domestic violence to further risk from 'high needs' homeless persons. The Homeless Agency's 2005 survey found that there were 220 homeless families with children under 18 in Dublin. 463 children were residing in B&Bs and of these children, 41 percent were aged under-five years. The majority of these families (73 percent) were in emergency bed & breakfast accommodation (Homeless Agency 2005).

In my opinion, B&B and mixed hostel accommodation is completely unsuitable for women and children in crisis who are fleeing domestic violence. We know from our work in Sonas that specialist support, advice and advocacy work is needed. Support workers spend hours talking to and listening to women who need enormous amounts of emotional support. This emotional support, as well as specialist advice on safety planning and court accompaniment that refuges and specialist domestic violence services provide are absent in B&Bs and most homeless hostels. Ireland urgently needs targets for the reduction of the use of B&B accommodation for families including those who are homeless due to domestic violence. The UK has implemented targeted measures for B&B reduction and Ireland should follow suit.

Move on accommodation – transitional and permanent housing

Sonas provides a specialist domestic violence transitional housing service. Other voluntary domestic violence organisations also provide small numbers of units around the country. A recent HSE report on domestic violence (prepared by NUIG), highlights the need for refuge, transitional and permanent housing to respond to the accommodation needs of victims. I hope that this is reflected, via identified lead agencies and ring-fenced resources, in the forthcoming HSE policy and a national action plan.

The local authority response

The local authorities, with the HSE local offices, have a significant role in responding to homelessness as a result of domestic violence. Firstly, the local authorities record causes of homelessness in their assessment of homeless and housing eligibility for women who are out of home due to domestic violence. Local authority policies and practices directly impact on the eligibility of female home-owners, on women who have had to flee their area of origin to be safe and on women without residency status. Secondly, the ways in which local authorities deal with housing management and tenancy issues for a woman who is a victim of domestic violence, who is a joint local authority tenant with the perpetrator, has very serious implications for whether she can stay in the family home (or indeed whether she can access local authority housing in the future).

There appear to be increasing numbers of women who are joint owners of the family home who are accessing refuge and applying for homeless services. I believe this is due in part to decreasing housing affordability. These women may have very limited housing options due to the interpretation of eligibility for homeless accommodation by local authorities. Depending on the local authority interpretation and local practice, a woman may be unable to access homeless services or social housing until after lengthy civil proceedings for separation or an inadequate settlement from the sale of the home. These processes can take two to three years to conclude.

There is a need for an appropriate, standardised approach to service provision for victims of domestic violence, together with policy guidelines regarding domestic violence for local authorities and the HSE to take account of 'eligibility' and housing management/tenancy issues.

The HSE Response

As previously mentioned, the HSE has a key role in meeting the needs of women who are out of home due to domestic violence in refuges and in homeless hostels because these women may need addiction, mental health and child protection services. Social workers are sometimes involved and families may need family support services. Furthermore, because the HSE has a lead role in national homeless initiatives, its role in funding domestic violence-related services is substantial.

In most areas, the HSE funds refuges. But in a number of other areas the local authority pays Section 10 funding to the refuges. In the Dublin area, transitional housing is funded through the Homeless Agency by both the HSE and the relevant local authority (broadly with the care element being funded by the HSE and the settlement and housing service being funded by the local authority). However, outside Dublin confusion within complex funding schemes leads to delays in getting services established.

From Sonas' experience with partners around the country, to date, transitional domestic violence housing services have been funded only through local authority Section 10 funding. The agencies are currently proposing joint (local authority and HSE) funding for the development of new domestic violence transitional housing services, but the level of funding from each body is unclear and uncertain. In the absence of clear guidelines, funding is open to local interpretation and inconsistencies between areas and within the HSE result. The lead-in time for new services is lengthening partly because of this confusion.

Is there a national policy response to homelessness due to domestic violence?

Whether in trying to build a much-needed refuge or in housing homeless victims of domestic violence, responsible agencies are acting separately, thus making a coherent response more difficult.

The existing national homeless strategy, *Homelessness – an Integrated Strategy (2000)*, makes only one reference to domestic violence. This reference is in relation to the shortage of short-term hostel accommodation

for families who must go into bed and breakfast accommodation or be split up (including the victims of domestic violence).

The HSE, despite financially supporting domestic violence services including refuges, hostels and specialist homeless providers like Sonas, has no national policy on domestic violence. Likewise, local authorities have no policies on the link between domestic violence and homelessness or housing needs. Domestic violence is rarely, if ever, referred to in housing or local homeless action plans.

The new government strategy on homelessness, *The Way Home*, sets out a programme of action on homelessness. It is in final draft form at this stage and, at the time of writing, has yet to be launched. But having seen a draft of the report, the link between domestic violence and homelessness is acknowledged and the report highlights the need for research into domestic violence and homelessness. In my opinion, the new national office for domestic violence, Cosc, will play a key role in implementing the goals of this strategy. Under the aegis of the Department of Justice, Equality and Law Reform, Cosc, also called the Irish Office for the Prevention of Domestic Violence, is the first dedicated government office with responsibility for ensuring the delivery of a well co-ordinated 'whole of government' response to domestic, sexual and gender-based violence. Cosc's mission covers issues relating to domestic, sexual and gender-based violence against women and men, including older people. Cosc works with organisations in the sector to ensure the delivery of well co-ordinated services for victims, raises awareness about the level and impact of these crimes and of local services that are available for victims, develops strategies in line with international best practices for preventing and dealing with these crimes, and develops standards for service delivery and for training programmes.

Cosc meets regularly with the HSE and DoEHLG to ensure co-ordination between these agencies in relation to domestic violence. It will be working with DoEHLG to bring forward research on domestic violence-related homelessness and is planning to carry out a mapping exercise to clarify the scale and spread of existing services. This will take account of the current level of service provision and occupancy. I urge Cosc to take a lead role in issuing guidelines on:

- *Accommodation and support options for households experiencing domestic violence to local authorities and health services.*
- *Reducing domestic violence and improving accommodation provision.*

Cosc will soon be developing a national action plan on domestic violence. I hope that the plan will assign responsibilities to the relevant government departments and that it cascades down to local agencies (including local authorities, HSE, and Garda Síochána) and then to the voluntary sector to address some of the practical and policy difficulties that I have mentioned in this essay.

In addition to Cosc, the HSE is important in developing national policy on domestic violence and homelessness because it provides most of the funding to the domestic violence sector (for refuges and supports services) and a substantial amount towards homeless services, some of which are specialist domestic violence services. There is, however, a need for a clear organisational policy to address inconsistencies between local offices and regions. I welcome the imminent development of a HSE national policy on domestic violence that would eliminate these inconsistencies.

The DoEHLG's policy response to domestic violence is not formal. Again, a departmental policy would be helpful, as would clear guidelines to local authorities (perhaps in the form of circulars) that would assist in ensuring consistency of practice across local authority areas, particularly on homeless eligibility and housing management of tenants who are victims of domestic violence. The forthcoming national homeless strategy provides an opportunity to put forth a domestic violence homeless/housing policy.

The lack of an integrated framework by local authorities and the health sector to encompass crisis refuge, supported housing and long-term housing needs must be addressed.

Conclusion

In this essay I have looked at the issue of homelessness due to domestic violence, particularly as it affects women and children. While it may not be topical in the media or indeed in the homelessness sector, I have highlighted the link between domestic violence and homelessness. While we have no concrete data on the extent of domestic violence-related homelessness in Ireland, comparable studies indicate that up to 40-60 percent of women may be homeless as a result of domestic violence (Reeve, Goudie & Casey 2007). It is necessary to undertake a national study that can help us get a full picture of the problem of homelessness due to domestic violence and allow us to think strategically and plan appropriate responses.

Many issues arise from an examination of current responses. Refuges are taking in increasing numbers of women with more complex needs (as are many homeless providers). Consequently, there is a need to work closely with addiction, mental health and child protection services in a case management approach. Residency status, housing affordability and the lengthy civil court system are all impacting on a woman's eligibility for housing and her move-on options from refuge, B&B or hostel.

Ireland needs a clear, coherent national policy and a national action plan on domestic violence (a part of which addresses homelessness due to domestic violence) that cascades down to local authorities, HSE local offices, other public agencies and to the voluntary sector. Cosc, working with the HSE and DoEHLG, should play a key role in the development of this plan. This national action plan should be followed with:

Guidelines and codes of practice for local authorities and service providers.

Clarification of roles and responsibilities of DoEHLG, local authorities and HSE (and funding).

Assigning a key strategic role to the local authorities in planning for future refuge provision to meet international guidelines on levels of provision.

Changing housing legislation to:

Incorporate domestic violence in the definition of homeless.

Treat breaches of barring orders/protection order as breaches of tenancy agreements and reverting to a sole tenancy for the victim.

Interpret violence against a person on the tenancy as anti-social behaviour and therefore a breach of tenancy.

Such a 'whole of government' approach (with an action plan clarifying roles and responsibilities at all levels and a timeline for delivery) would go a long way to ensuring a strategic approach to both policy and practice to prevent domestic violence. It would also take account of the link between domestic violence and homelessness for the victims.

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Homelessness and care

Chapter 11:

**The care and case management of homeless service users in Dublin:
developing the practical and structural supports**

Elaine Butler

CHAPTER 11

CHAPTER 11

THE CARE AND CASE MANAGEMENT OF HOMELESS SERVICE USERS IN DUBLIN: DEVELOPING THE PRACTICAL AND STRUCTURAL SUPPORTS

ELAINE BUTLER

“The ultimate aim to be borne in mind at all times is to achieve seamless service delivery for homeless people, to focus on positive outcomes and to prevent those in need from ‘falling through the cracks’”

Eustace & Clarke 2005: 11

Introduction

Care and Case Management of complex needs in homelessness is a core aspect of current developments within homeless service provision in the Dublin region. Structures and processes are in development to improve collaborative service provision. While far from completed, the process of introducing a standardised approach to care and case management of homeless persons with complex needs is well underway. Significant steps have been undertaken to promote greater efficacy in responding to complex needs. This essay will provide an overview of these recent developments, while providing a review of what is meant by case management, evidence of efficacy, and key challenges inherent in such a process.

What is care and case management?

It's important at the outset to be clear about what is meant by Care and Case Management. The term has been used in many ways, and in many settings. This led early reviewers such as Schwartz et al. (1982) to compare case management to a Rorschach Test¹ in that the concept was so formless that agencies projected onto it particular solutions to whatever problems they faced. The term has since been narrowed to promote clarity, with key elements identified, and a typology of case management provided.

Case management has been described as “the glue that binds otherwise fragmented services into arrangements that respond to the unique and changing needs of clients” (Turner & TenHoor 1978). Some two decades later, Solomon & Draine (1995) defined case management as the engagement of a client in a system of services by an accountable professional or team of professionals who advocate on the client's behalf. This definition clarifies the need for coordination of a range of service providers intervening with a client simultaneously, which is the crux of case management.

Another key point to note is that case management is not for everyone!

“It is a common misconception that all cases should be included in the case management process. It is important to be clear from the outset that the care and case management model is necessary in the case of individuals or families who have complex or multiple needs and it is not envisaged that it will be necessary for all people who are homeless”

Homeless Agency 2004: 17

In the US, case management has been seen to provide a better matching of needs and resources. This is especially true when focussing on those individuals with very complex needs who have been referred to as ‘Chronic Homeless’.² It has not been found to be substantially more expensive to house the ‘chronically

1 The Rorschach inkblot test is a method of psychological evaluation, inviting individuals to identify/interpret meaning from inkblots presented to them.

2 Three categories of service users are evident within the US system:

- Transitional Homeless – These homeless service users form 80% of the entire homeless population. They occupy 33% of homeless beds and typically engage with homeless services for a very brief period, usually 1 day.

- Episodic Homeless – 9% of the homeless population occupying 17% of homeless beds, and are episodic in their repeated entry in and out of homeless services (between episodes in homeless services they are in hospital/prison, or sleeping rough/unstable accommodation).
- Chronic Homeless – 11% of homeless people occupy 50% of homeless beds, using emergency/shelter accommodation for lengthy periods: years, even decades in some cases. This could also be referred to as the 80:20 rule: 20% of service users are episodic or chronic, while the vast majority pass through homeless services very briefly.

homeless' who have complex service needs than to leave them homeless (ie: in emergency shelter-type accommodation). While costs have been found to be perhaps \$1,000 or \$2,000 more, outcomes are dramatically different.

The theoretical foundations for the case management model are grounded in psychological and sociological schools of thought including humanistic, psychodynamic, motivational theory, behavioural theory, strengths based and systems theory. Rothman (1991) espouses that this model can contribute to the development of practice theory for long-term clients who are 'highly impaired or dependent'. He states that most theories for help-giving in social work psychology and other human services assume that clients are experiencing problems that impede their 'normal' functioning and personal growth and that giving assistance will be curative/restorative. These theories also assume that clients will return to previous normal functioning or will achieve some new and higher level of performance. Such theories are typically drawn from Freudian/neo-Freudian sources or from an array of other perspectives including cognitive and ecological. There are few examples of practice theories explicitly oriented to the long-term dependent client whose condition or difficulty is fundamentally chronic or in decline and whose optimal performance rather than the cure is the objective. A coherent model of case management supports this particular kind of theoretical development.

Case Management approaches must be cognisant of two different levels of operating.

Firstly at client level: this involves responding to client needs on an individual basis. This is 'case management'. A case manager is responsible for direct intervention with the client in assessing needs and developing an interagency care plan. While a number of key-workers may be linking with the client from a range of different organisations, the case manager takes the role of lead key-worker, and is responsible for coordinating the provision of a range of services to respond to the complex needs of that client. The case manager undertakes regular case reviews and will generally have most contact with the service user. They hold the central service user's file and Interagency Care Plan, and report Gaps and Blocks to a care manager.

Bernatovitz & Spence (2001) highlight that the case manager's role can be taken on by staff in a variety of services:

"Case management is not a job but a role that can be played intermittently by different individuals at different times, with a definite set of core competencies that can be developed through a carefully designed training programme" (20)

The Case Manager should have a set of core competencies:

- Understands and employs case management principles,
- Keeps up-to date case file: assessment, care plan, reports,
- Holds regular case reviews,
- Coordinates appropriate services: identifying, advocating for the client, ensuring timely delivery, evaluating their effectiveness and amending plans as required,
- Identifies and measures outcomes,
- Knows when and how to close a case.

Bernatovitz & Spence 2001: 20

The second level of operating is at a structural or policy level referred to as 'care management'. This involves sectoral review of policies, procedures and service provision which should support the case manager in their work. A care manager, who operates at a senior level in service planning and development, undertakes this role. The care manager is responsible for focussing on structures and policies, responding to gaps and blocks identified by the case manager, and improving service delivery planning and a continuum of care.

Effective care and case management should incorporate an analysis of both of these operating levels, to reflect the continuous reciprocal systemic exchange between the client and their environmental situation (Germaine & Gitterman 1987).

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Types of case management

A typology has been developed to elucidate differences in approaches to case management. This typology involves four levels of engagement, ranging from linkage, through brokerage to intensive. Lakeman (2008) provides an overview of these case management types:

- Linkage: The facilitation of information about and access to existing services.
- Brokerage: The active facilitation of priority access to services.
- Service Delivery: The direct provision of health and welfare services such as counselling, treatment or psychosocial support.
- Intensive Case Management: Intensive engagement with the service user supporting access to services, with a strong emphasis on outreach and advocacy.³

Kantor and Miller (1988 in Rosen & Teesson, 2001: 732) describe this typology of case management models quite simply, to highlight the varying emphasis on the level of engagement with the service user:

- Linkage: The travel agent model – where the professional just sits behind a desk offering advice.
- Brokerage: The travel companion model – where the service provider goes with you but without any special expertise or training.
- Intensive Case Management: The travel guide model – where the staff member will not only be there and do things with you (rather than doing things to you), but also has appropriate training, experience and expertise to know the most scenic routes, how to take short cuts without getting lost, how to reliably avoid the pitfalls, and to arrive reliably at the desired destination.

There is a requirement to have each of these levels of case management available, in order to respond effectively to the particular needs and level of functioning of the service user. However, there is an added emphasis on the availability of Intensive Case Management to homeless service users with complex needs.

Intensive Case Management is:

“an aggressive comprehensive approach to accessing and securing basic health and mental health services. It involves the functions common to most case management efforts: identification and outreach, assessment, service planning, service linkage, monitoring of service delivery and advocacy. However, two of the functions – outreach and advocacy – receive relatively more emphasis within intensive case management”

Rog, Andranovich & Rosenblum 1987: 79

While a variety of models of case management exist⁴, one model in particular is showing positive results currently: Assertive Community Treatment (ACT). An effective targeting of resources in the area of Intensive Case Management has shown significant impact in a range of fields internationally.

Wolff et al (1997) highlight essential differences between Brokerage and ACT. In brokered case management, a typical caseload would be 50-100 cases. The case manager would rarely see the service user outside of their office, and drop-out rates would be higher. In ACT the average caseload would be 10-15 cases. The case manager would frequently meet service users outside of an office environment and generally have fewer limitations on the duration of treatment. Advocacy is a major element of the case manager's work.

What's the rationale behind case management?

Case management has evolved in response to increasing complexity in the provision of care services to clients. Over the past few decades, a number of professions have experienced significant increases in the level of complexity of care provision. Rothman (1991) refers to a number of these fields leading to the emergence of case management. In gerontology: advances in medical science and life expectancy, coupled with a diminished responsibility of families to attend to the elderly, accentuated the need for professional continuing care. In mental health: the de-institutionalisation of mental hospitals and the advent of psychotropic medication led to a need for more outreach-based interventions and supports. Similarly, in the field of healthcare: advances in

3 Advocacy involves an affirmative/assertive approach to assisting a client in receiving relevant services that are being withheld. There are a number of intensity levels of assertive advocacy including: discussion, persuasion, prodding and coercion. Advocacy requires a sophisticated understanding of how organisations work, including an appreciation of organisational politics. (Rothman 1991)

4 Thornicroft (1991) identified 12 axes of case management to compare case management programmes.

working with people with disabilities, in particular in the community setting led to case management as an alternative to hospital-based interventions. With regard to child welfare developments: a number of factors led to a case management approach emerging. These include increased family disorganisation, divorce, violence and child abuse, and dependent children requiring care outside natural families.

Within the field of homelessness, an increasingly complex picture is developing in relation to our understanding of the homeless population and required interventions. The homeless population is extremely diverse, and homogenous responses are proving of little effect. The ETHOS typology provides a basic categorisation of homelessness, (see O'Connor, Chapter 6) while the recently completed pilot of The Holistic Needs Assessment in Dublin provides opportunities for identifying service users' needs on an in-depth individualised basis.

On its own, a single homeless organisation can experience great difficulty in responding to complex needs. As a result, a standardised approach to case management has become a necessity in homeless services. Eustace & Clarke (2005) stated this clearly in their recent review of the Dublin context:

"The time is ripe to take a coordinated and integrated approach to the implementation of Care and Case Management across the sector. Elements of good practice are already in place within the sector and some organisations are in the process of implementing case management locally. However, this work tends to be piecemeal in that it is organisation specific and unable to maximise the opportunities for a standardised, holistic and more outcome-focussed process across the Homeless Sector."

Eustace and Clarke 2005: 5

The Dublin experience, in introducing a standardised approach to case management of homeless service users, will be explored below.

What about efficacy, does it work?

In essence it does work! There has been consistent evidence of the value of the case management approach. When implemented effectively, case management has been shown internationally to significantly improve the delivery of services to clients, meeting of clients' needs and achieving positive outcomes with clients. Care and Case Management avoids sequential and parallel separate models of service delivery, and promotes integrated service delivery.

Case management has been found to be an effective response to the service needs of people with serious mental illness (Bond et al. 1988, Stein & Test 1980, Solomon & Draine 1995). A study conducted by First & Rife (1990) saw positive outcomes, in that within the first 27 months of a demonstration program in Indiana, case management activities were effective in placing 63.3% of people who were homeless with mental health problems, in housing. Rota-Bartelink & Lipmann (2007) found that:

"There is consistency in the conclusion that successful interventions for people with such disorders require integrated, comprehensive, individualized, and intensive services. The common features of successful interventions include the following: management strategies that are highly individualized for each client; investigations and assessments that are comprehensive, incorporating medical, psychiatric, social, and environmental approaches; an intervention process that is time and staff intensive; highly integrated multidisciplinary approaches (Gresham 2006)."

Assertive Community Treatment (ACT), in particular, has been effective in meeting the needs of marginal groups when based in settings where clients live and work. This approach has proven particularly useful for clients who experience unique hindrances to community integration such as homelessness, substance use and criminal involvement (Griffin 1990, Levine et al. 1986, Rog et al. 1987). ACT has been found to provide better client outcomes at no greater cost, proving more cost-effective than brokered case management for clients with complex needs (Wolff et al. 1997).

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Key challenges

Establishing a standardised approach to case management, and facilitating sectoral change in the provision of services to homeless people with complex needs, cannot be undertaken without comprehending the challenges which exist in this field. Basic difficulties exist for both the service user and the service provider such as a lack of consistency in terminology and approach, and an absence of clear quality standards.

In the UK a number of challenges to this process were identified by Shelter (2004):

- Case meetings convened with no clear purpose.
- Lack of trust among service providers due to competition for funding, personality clashes, or poor collaborative history.
- Agencies willing to participate but unable to attend meetings.
- Confusion regarding confidentiality and information sharing between agencies.
- Lack of clarity regarding referral procedures.
- Misunderstandings about the roles of services. Difficulty in recording and monitoring outputs required by agencies

A number of recent studies in the Dublin region reported problems which could undermine the introduction of a standardised approach to case management. In 2005, Brooke noted that:

“a number of projects with extremely low staff/ client ratios operated key working and care planning systems. It is difficult to see quite how this could be achieved with such low staffing levels” (:22)

A Care and Case Management review by Eustace and Clarke, for the Homeless Agency, in 2005 found substantial variation between practices and policies among Dublin homeless service providers, different interpretations of case management principles and practice.

An evaluation of Emergency Accommodation Providers in the Dublin region in 2007 reported that:

“Assessment, key working and care planning and review arrangements in the emergency accommodation sector were inconsistent. There were some examples of very good practice but there were also a number of services where there was only partial assessment, key working or care-planning and review” (:15)

Similarly, a review of Transitional Housing services in Dublin found substantial variation in practice: “Some key worker relationships seem to be a lot more structured than other key worker relationships” (Homeless Agency 2007: 57). There were differences in the regularity of key worker meetings with service users, focus of meetings, and existence of a list of agreed tasks rather than a casual relationship.

A number of key challenges to developing effective care and case management structures and processes in Dublin Region were highlighted by Eustace & Clarke (2005). The Homeless Agency has, in the three years since this report was produced, undertaken a series of initiatives to counteract these challenges, and prepare for the introduction of a standardised approach to care and case management. Table 1 (below) provides an overview of key challenges identified and actions undertaken.

Table 1: Key challenges to case management

	Key challenges	Responses/actions by Homeless Agency
1.	Organisational Commitment, particularly at senior level	<ul style="list-style-type: none"> • Care and Case Management Steering Group and thematic subgroups established • Research on commitment and capacity
2.	Shared Terminology and clear understanding of concepts	<ul style="list-style-type: none"> • Developed definitions • Developed Holistic Needs Assessment • Developed Interagency Protocols • Briefing sessions, seminars, training to clarify terminology
3.	Networking Opportunities	<ul style="list-style-type: none"> • Homeless Agency facilitates Networks, and hosts briefing sessions, seminars, training
4.	Training and Development for case managers	<ul style="list-style-type: none"> • Developed accredited Case Manager Training course with an education provider
5.	Communication within and between organisations and with clients to overcome resistance and blocks	<ul style="list-style-type: none"> • Developed "Gaps and Blocks Reporting Protocol" and Grievance Procedures for service user, and service provider
6.	Confidentiality protocols	<ul style="list-style-type: none"> • Developed Interagency Confidentiality and Data Protection protocols. Consultation with Office of Data Protection and broad range of stakeholders, including service user fora
7.	Tools for interagency working: "How to case manage": eg assessment, care planning, etc	<ul style="list-style-type: none"> • Developed Interagency Protocols, in consultation with stakeholders, ready for pilot phase

Adapted from Eustace & Clarke 2005

The overall recommendation emerging from this report was that:

"The Model of Good Practice Care and Case Management⁵ should be communicated, discussed and agreed for implementation across the Homeless Sector over the next two to three years".

Eustace & Clarke 2005: 7

In doing this, they recommended 11 specific things to do:

1. Gradual roll-out: begin with organisations already engaged in case management locally.
2. Establish a high level steering group.
3. Appoint Integrated Services Coordinator.
4. Provide Briefing Meetings and Seminars.
5. Review/audit existing policies, practices and guidelines within the sector.
6. Service Level Agreements to include clauses linking funding to a demonstrated commitment to care and case management.
7. Care and Case Management training and information programme for management and staff.
8. Resources for case managers.
9. Caseload for first six months to begin small.
10. Review LINK in the context of care and case management.
11. Use an action research methodology to evaluate the care and case management strategy.

Eustace & Clarke 2005: 7

⁵ Specifically: sections 2.6-2.7 of this report

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The Homeless Agency Partnership has undertaken each of these actions within the last three years, leading to the establishment of a variety of care and case management initiatives including a pilot case management project in the Dublin region.

Introducing a standardised approach to care and case management in Dublin

The Care and Case Management Strategy of the Homeless Agency partnership builds on three successive Action Plans of the Homeless Agency, and forms Core Action 4 of the current action plan *A Key to the Door* (2007). This strategy includes a number of core components within an overarching structure. This overarching structure has been developed to facilitate care management at structural and policy level, while a number of initiatives have been instigated to support case management at front-line service delivery level, supporting case managers' interventions with complex cases.

The Care and Case Management Steering Group was established in June 2007, and consists of senior level representation from organisations with a responsibility in the provision of services to homeless people.⁶ This Steering Group meets quarterly in order to review care and case management proposals from a number of Thematic Subgroups. Thematic subgroups are time limited⁷ groups which form to explore care and case management interventions, processes and policies focussing on particular groups, or topic areas. Membership is comprised of individuals with expertise in that area, or a specific remit in service planning/provision. The Thematic Subgroups have the express task of developing policy or practice proposals for the Care and Case Management Steering Group. The Thematic Subgroup's topic areas include the following:

- Interagency Care and Case Management Protocols/guidelines for case managers.
- Prison Discharge Planning.
- Care and Case Management of Women with complex needs.
- Care and Case Management of Repeat Nightbus⁸ presentations.
- Care and Case Management of Homeless Sex Offenders.
- Developing a model of the continuum of care.
- Care and Case Management of Children in Families.

Others will include: Homeless Youth, and Hospital Discharge Planning.

It is envisaged that this unprecedented and targeted focus on case management of complex needs within homeless and mainstream services will produce positive impact within the coming months and years, both for people experiencing homelessness currently and those who will do so in future.

Interagency Collaboration has been further supported by two other initiatives under the auspices of the Homeless Agency. Firstly the introduction of the Holistic Needs Assessment⁹, (HNA) as a standardised approach to the assessment of individuals across homeless service providers, and secondly facilitation of a range of service-based Networks.¹⁰

To provide some insight into the work of the subgroups, The Nightbus Subgroup has led to greater clarity about the usage of this service, and required responses to service users with complex needs accessing this Nightbus. In Dublin, many service providers would concur with the US categorisation of homeless services users, and their levels of uptake of emergency beds, described earlier. A recent review of those using the Dublin City Local Authority night bus emergency bed service¹¹, found that 4 percent of those using this emergency accommodation service occupied 33 percent of available beds through this service. Of this relatively small cohort of individuals, an estimated 90 percent had high/complex needs, which were not being addressed and were using the night bus repeatedly. This review proposed that if the core cohort of 38 repeat night bus users could have their needs addressed through a planned pathway or continuum of care from the night bus into other services, then this would free up one third of the capacity of the night bus to focus on other potential rough sleepers. Intensive case management is required to respond to complex needs, and this cohort was prioritised for inclusion in the case management pilot along with other groups identified.

6 This includes: HSE, Local Authority, National Drug Strategy, Prison, Probation, Voluntary Sector, Mental Health, HPU, others

7 Each Thematic Subgroup commits to meet and develop proposals within a three month period, after which a report is presented to the Care and Case Management Steering Group for exploration and ratification at senior level by service providers.

8 Local Authority service transporting individuals to emergency accommodation on a nightly basis

9 The Holistic Needs Assessment is a common form of assessment and care planning which minimises the need for service users to repeat their story, while maximising opportunities to plan effective responses. The HNA Pilot began in 2006, and is currently piloting in 40 homeless and other services. A Review conducted in June 2007 was positive, indicating that the HNA provides clarity across services in relation to the level and range of needs of a service user. An Evaluation is currently underway, as the pilot ends its two year schedule. A report on this evaluation is due in the coming weeks.

10 Networks include: Emergency (Outreach Services) Network, Emergency Accommodation Providers Network, Transitional Housing Providers Network, Settlement Service Providers Network, Learning and Performance Network, Information Network, Training, Education and Employment Network.

11 Integrated Services Coordinator's Report to Homeless Agency Care and Case Management Steering Group: April 2008.

The Interagency Protocols subgroup in particular has led to the development of case management guidelines for practicing case managers. The pilot project which seeks to review the use of these guidelines in practice, in preparation for their introduction across the Dublin region, began in May 2008. This Case Management Interagency Protocols Pilot is described below.

Interagency protocols pilot overview

The development of Interagency Case management protocols has been on the agenda of three successive Homeless Agency Action Plans. It has also been emphasised as a priority in the National Drug Strategy Rehabilitation Report. In collaboration with a leading drug rehabilitation case management service – the Progression Routes Initiative – the Homeless Agency facilitated the development of a draft set of protocols for case managers. This partnership was formed to strategically increase co-ordination between Drugs and Homeless Services, which have a substantial shared client base.¹² During the consultation period, over 22 services¹³ with a remit of working with service users with complex needs were consulted, including service user fora. The protocols cover seven key areas in relation to case management:

1. Initial assessment/establishing lead agency
2. Referral process
3. Guidelines for interagency case meetings
4. Confidentiality and data protection
5. Reporting of gaps and blocks
6. Grievance procedure for service users
7. Grievance procedure for service providers

The Protocols Pilot consists of two phases, of six months duration each. Phase 1 is currently underway, having begun in May 2008. This phase is employing Draft 8 of the protocols, with a view to refining them in preparation for the next phase. As a result of an open invitation for services to participate, a mix of 22 NGOs and statutory services were selected to participate in the first phase: both homeless and drug services. While an emphasis on lower threshold services was clear, the full spectrum of low, medium and high threshold services were included, to promote an effective progression pathway and continuum of care. Thirty-two case managers are involved, who are working with 85-95 cases.¹⁴ Cases during this phase are limited to single men/women, with a view to broadening this to families and youth in the next phase. Case-loads are purposefully low, to allow intensive case management to be effected.¹⁵ All case managers will be using the Holistic Needs Assessment. The geographical boundary for the first phase includes North (and some of South) Inner City Dublin.

Phase two will begin in January 2009. This phase will employ a further refined Draft 9 of the protocols, with a view to preparing them for implementation across homeless and drug services. A further open invitation for services to participate will be issued, and it is envisaged that a further 20-25 NGOs and statutory services will participate in the second phase: again, both homeless and drug services. Low, medium and high threshold services will also be included. Cases during this phase will include families and youth. The geographical boundary for the second phase will be the full Dublin region.

A process evaluation will be undertaken, employing an action research methodology throughout the pilot. On completion of Phase 2 an Evaluation Report will be produced.

In terms of supports for case managers, a number of supports have been developed and are being developed:

- **Structural supports:** Two key service providers (Health Service and Local Authority) have identified named care managers who will operate as senior level supports to case managers, responding to gaps and blocks identified in the interagency care plans, and refining policy/service planning to respond to needs identified. The Care and Case Management Steering Group will also oversee the development of policy solutions on a sectoral basis.
- **Case Management Guidebook:** Will be developed to accompany the Holistic Needs Assessment. This guidebook will detail appropriate interventions to employ on the basis of any particular need identified through the HNA. This guidebook will also clarify operational and policy making structures, in a range of relevant services, to support the work of the case manager in negotiating, brokering and advocating for services.

12 Various reports identify an overlap of between 40%-60% of service users between drugs and homeless services

14 Cases comprise of single men/ women with complex needs, including two prioritised groups of repeat night bus users, and women with complex needs.

13 Membership of the Interagency Protocols Subgroup included: DePaul Trust, HPU, Gateway, SOILSE, HSE Multi-D Team, SAOL, Access Team, South Dublin City Council, Fingal County Council, Focus Ireland, Dublin Simon, HSE Prison Liaison, DCC, SNUG, BRIDGE, HSE Child Protection, UISCE, NWT&DP, Ana Liffey, SOILSE, Dublin Simon, Peter McVerry Trust, HSE, RIS. This subgroup met between July and September 2007 to refine and develop interagency protocols for case managers. Other services were also consulted on an individual basis, eg: Methadone clinics, social work teams and others.

15 Case loads are pro-rata less than 10 per case manager.

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- **Skills Development:** A six month accredited case management training course has been developed to facilitate the skills development of case managers in applying these protocols, and all case managers participating in the pilot project are currently engaged in this case management course. A further brief course on Keyworking and Care Planning Skills has been developed to respond to identified needs.
- **Line management supports:** Pilot Implementation Advisors have been identified in each project to act as a central point of communication between pilot organisers and case managers. Training and briefings for line managers involved in this pilot have been provided, to support effective processes across pilot sites.

The emphasis during this pilot will be on the macro and micro levels: both care management and case management, as neither can be truly effective in isolation from the other. Throughout the pilot, an action research approach will support a continuous reflection and refinement on practice: praxis. At case management level, core competencies are being developed and supported, protocols have been provided, and a guidebook will be available, all of which will support more effective collaborative service responses to individual complex cases. At care management level new structures, roles, frameworks, and a clearer continuum of care will inform policy development and service planning.

Conclusion

In conclusion, housing people who are homeless is a resolvable issue, which has been perpetuated by a lack of a clear continuum of care, relevant to needs. Within homelessness, resources must be reallocated to appropriate responses to complex cases. Care and case management of complex needs in homelessness has been shown to improve service delivery and outcomes for service users with particularly complex needs. Coupled with evidence of its validity as an effective use of resources, the argument is clear for introducing standardised case management structures and processes in the Dublin region. This essay has provided an overview of research findings relating to care and case management, and the strategy emerging. While far from completed, the process of introducing a standardised approach to care and case management of homeless persons with complex needs is underway, and aims to establish evidence of needs coupled with a mechanism for responding to those needs in an integrated way. The approaching end of term for the Homeless Agency's current action plan (2010) will provide an opportunity to review the structures and processes undertaken, with an emphasis on establishing more positive outcomes for people who have traditionally 'fallen between the cracks'.

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Homelessness and health

Chapter 12:

**Primary care and access to health services in Ireland:
the example of the Safetynet initiative for homeless persons**

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Health and homelessness: the Cork model

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CHAPTER 12

PRIMARY CARE AND ACCESS TO HEALTH SERVICES IN IRELAND: THE EXAMPLE OF THE SAFETYNET INITIATIVE FOR HOMELESS PERSONS

FRANK MILLS, BRIAN MELAUGH AND AUSTIN O'CARROLL

Launched in 2007, the Primary Health Care Safetynet Service for the Homeless aims to “form a cohesive and comprehensive primary health care service to target people who are homeless in Dublin”. The purpose of this essay is to outline reasons why a safetynet service for the homeless was, and still is, considered necessary. The disproportionately high rates of morbidity and mortality amongst Dublin's homeless population illustrate, amongst other issues, a gap in health provision. This essay will set Safetynet in context by providing a rationale for how the service is part of a comprehensive model of provision for the homeless population. It outlines how the service functions as a network organisation to achieve its aim of forming a cohesive and comprehensive primary health care service for homeless people in Dublin. Finally, the essay explores how the service links to the wider Irish primary care reform reflected in the government strategy, *Primary Care: A New Direction*. Case vignettes will outline the impact of Safetynet on people who access the service and offer a flavour of the work that Safetynet provides. These vignettes have been adapted to ensure that the anonymity of clients is protected.

Despite Ireland's unprecedented growth in economic wealth over the last 10 years, the 'Celtic Tiger' era bore witness to ongoing health inequality. The health of homeless people, for example, remained poor in comparison to that of the general population. Research conducted by O'Reilly & O'Carroll (2005) compared the health status of the homeless to that of a 1997 research study (Holohan 1997) and highlights that the physical and mental health of homeless people have not improved. In fact, levels of illicit drug use and blood borne diseases, including HIV and hepatitis, have risen significantly.

These blood borne diseases, along with tuberculosis and conditions commonly found in the general population, result in homeless people having higher morbidity rates than members of the housed population. Furthermore, the international literature estimates that homeless adults have mortality rates 3.5-4 times greater than the housed population while homeless adolescents have a mortality rate 11 times greater than the non-homeless (Hibbs et al. 1994). It has been estimated that 33-50 percent of street youth have attempted suicide compared to studies of youth in general that indicate that 2-13 percent of this population attempt suicide. Research findings in both international and Irish literature highlight that homeless people have higher levels of mental health morbidity (including suicide) than the housed population (Folsom et al. 2005). A particularly vulnerable group are elderly homeless people who have both high mortality rates and high levels of cognitive impairment and mental illness (O'Connell et al. 2004).

Despite the body of research indicating that persons who are homeless are highly vulnerable to illness (Condon 2001), this population underutilise primary health care services (Focus Ireland 2001). International studies showing that homeless people have less access to medical insurance or free primary health care (Brush et al. 2001) have been replicated in Ireland and revealed that between 24 percent and 45 percent of homeless people do not have a medical card and are consequently dependent on Safetynet for free primary health care and medications. In 2008, O'Carroll and O'Reilly found that since 1997, the same proportion of homeless people (44 percent in 2008 and 45 percent in 1997) had no medical card despite the introduction of a range of initiatives to increase uptake of free entitlements to primary care.

Setting the Safetynet service in context

O'Reilly and O'Carroll's (2005) conceptual model for the delivery of health care to homeless people (see Figure 1) proposes that the majority of homeless people, along with the housed population, access health care through mainstream services. Safetynet services, by outreaching to hostels and services used by homeless people, provide healthcare for the subset of homeless people not accessing mainstream care. Lastly, they suggest that a small cohort of homeless people with complex, multi-factorial medical, psychological and social needs (such as those having significant physical and mental health problems, being addicted to alcohol or drugs and displaying challenging behaviours) require specialised services. This model provides a useful framework for examining the various initiatives that have been developed to improve access to appropriate health care for homeless people.

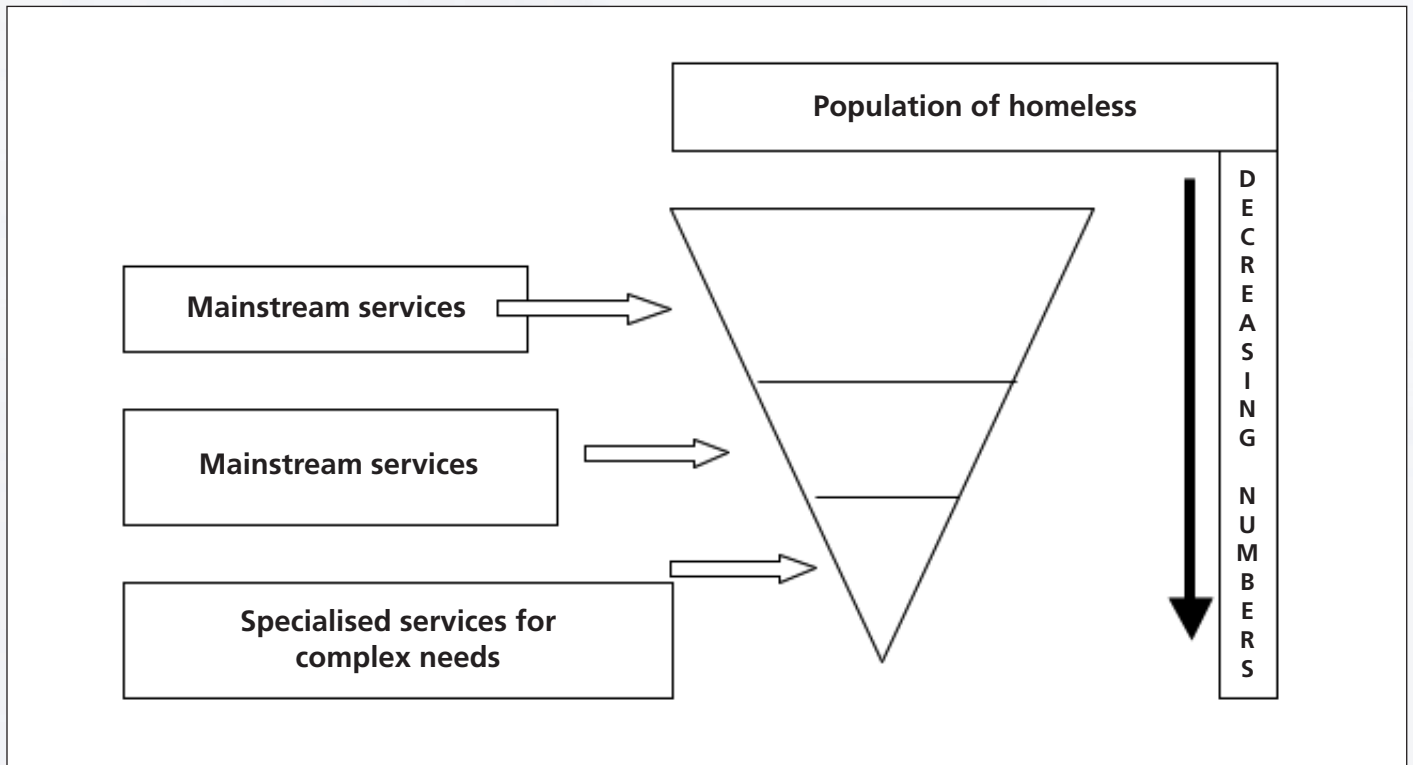


Figure 1: Conceptual model for the delivery of health care to homeless people

Level 1. Accessing mainstream services

To facilitate access to mainstream health services, O'Carroll and O'Reilly (2005) recommended a tracking mechanism for homeless people that would enable ascertainment of whether or not the person was registered with a general practice. Such tracking could be done by coordination between the social welfare and health systems. In a later study, O'Carroll and O'Reilly (2008) identified a problem in the provision of medical cards for homeless people whereby they were having their entitlement to free health care removed due to the fact that they failed to return the review form (which they usually did not receive due to their homeless status). In response, the Dublin Multidisciplinary Team Community Welfare Officer set up a mechanism whereby these review forms were sent to her and she would ensure they were returned. Despite these two examples, a general lack of Irish-based initiatives to facilitate access to mainstream services for homeless patients means international models of practice form the evidence-base for future planning:

- **Appointing a GP facilitator:** Three borough Primary Care Teams in London have appointed a GP Facilitator whose role is to work with the local authority and local primary care teams to improve access for homeless people to the individual practice teams. The facilitator has a role in developing pre- and postgraduate courses in the provision of primary health care for homeless patients. These courses aim to foster a future generation of doctors with the ability and desire to work effectively with homeless people.

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- **Registration letter:** The homeless unit in Richmond, London, provides all homeless people who are identified as having no access to primary health care with a registration letter. This letter encourages GP's to register the patient in their practice and provide a health check. The phone number for an officer in the homeless unit is provided should the GP require any assistance.
- **Link workers:** The Camden, St. Mungos and Waltham Forest boroughs in London have appointed specific link workers whose purpose is to act as a resource to clients by providing information and assistance in obtaining a GP and other primary health care services. Their work includes going to appointments with clients.

Level II. Primary care Safetynet services for people not accessing mainstream services

While catering for the health needs of homeless persons in mainstream health services is desirable, there is always a need for Safetynet services located within homeless services such as hostels, food halls and drop in centres. As Riley et al. (2003) commented, "it is the heterogeneity and specialist requirements of homeless people that make catering for their health needs problematic, particularly by overstretched GP services. As a consequence separate services or the work of innovative practitioners have been initiated to facilitate homeless people's access to health care." Thus Safetynet teams include nurses, local GPs, chiropodists, dentists, psychiatrists, counsellors, and occupational therapists and have flexible opening hours that fit into the unconventional daily timetables of homeless people. Drop-in services where people do not require an appointment are well recognised: Timms et al. (1997) noted that "conventional clinic times will not do for homeless patients". Such services exist throughout the United States, England and mainland Europe. In London alone, there are eight boroughs with such services.

In the National Health Service (NHS), GPs who provide Safetynet services have a Personal Medical Service (PMS) contract that is separate from their General Medical Service (GMS) contract. This allows the NHS and the local Primary Care Teams the flexibility to develop specific arrangements within areas where excluded groups are resident. It is a model that could be transferred to other health systems as it recognises that specific arrangements are necessary for such groups and that teams providing such services require additional resources.

To begin the process of introducing Safetynet services in Ireland, O'Carroll and O'Reilly (2005) recommended that the effects of hostel policies on health be identified and where these negatively impact the homeless population, reform should be implemented. Policies with a deleterious effect on the health of homeless people include:

- Discharging residents from hostels in the early morning regardless of their health status and condition exposes residents to further health complications.
- A lack of hostel staff trained in care assistance results in minimal assistance being provided to help homeless people who are having difficulties performing activities of daily living.
- A specific refusal by hostel staff to take responsibility for dispensing medications to residents, in particular those with mental health problems, because they are fearful of making a mistake, is to the detriment of homeless patients. Currently, there is no recognised protocol for dispensing drugs and as insurance cover arrangements are not in place, hostel staff are exposed to realistic risks in dispensing medication.
- At present in Ireland, there is no recognised policy or protocol for dealing with challenging behaviours or for barring clients displaying such behaviours. This lack of coordination means that people can be barred from hostel services without any right of appeal and without provision for linking with other agencies. This causes particular difficulty if the homeless person has health problems and ends up on the street, consequently losing access to services (health and otherwise).

Level III. Specialised services

In addition to investigating barriers to health care provision in hostels, O'Carroll and O'Reilly (2005) identified the exigency for specific facilities and services to address the needs of people with complex medical, psychological and social needs. An intermediate care facility designed for homeless people who have been discharged from hospital but who are too sick to return to their homeless accommodation or to the streets would, according to international evidence, improve health care for homeless people, reduce inappropriate use of secondary care services (such as accident and emergency and hospital inpatient services) and result in cost savings due to reduced inappropriate usage. This facility could also be utilised by homeless people who have been diagnosed in primary care with health conditions of such severity that homeless accommodation is unsuitable but where hospitalisation is unnecessary.

For homeless people who have complex medical and social problems and for whom no proper accommodation exists, a long-term inpatient facility with medical care would provide service options. As a final option for the specialised provision of services, O'Carroll and O'Reilly recommended both residential and non-residential substance abuse treatment programmes for homeless people. Services for homeless people with drug and/or alcohol addictions need to be flexible. They can be provided within services used by homeless people (as with Safetynet) but there also needs to be a range of specific residential and non-residential services.

Jane is a 35-year-old woman diagnosed with schizophrenia. Jane recently exhibited symptoms, including shouting and abusing hostel staff, linked to the use of cannabis (hash-induced psychosis). Jane decided to stop attending the psychiatric team for support and hostel staff were finding it increasingly difficult to manage her behaviour. Consequently it was decided that if Jane's behaviour did not improve, she would be asked to leave the hostel. She was referred to Safetynet and Safetynet staff worked with Jane to reduce her use of cannabis. She agreed to reduce her use when medication to help her sleep was provided. Because of the intervention, Jane's behaviour improved and Jane has remained in the hostel.

The development of Safetynet services in Ireland

The necessity for Safetynet-type services was recognised in Ireland in a 1995 review of homeless services by Dublin Corporation and the Eastern Health Board. The review recommended that primary care services should be located within homeless services (Dublin Corporation 1995). A number of subsequent reports reiterated this recommendation with specific requests for GP, nursing, dental and chiropody care provided within hostels (Holohan 1997).

In response to the 1995 report and subsequent research, the Health Service Executive began providing funding in 1999 to establish nurse-led primary health care services in the agencies where homeless people live and attend for support. By 2007, seven centres were established across Dublin. As the health centres developed, it became apparent that homeless people attending the centres had limited access to GP and dental services. Through a partnership approach with local GP practices, the Health Service Executive (HSE) and the voluntary sector, additional primary care services were developed. These initiatives included running GP clinics in the health centres, establishing a dental unit in Merchants Quay Ireland (one of the largest and busiest low threshold organisations in Ireland) and providing onsite podiatry services.

Because each centre developed separately in an organic manner, there was no formal communication or coordination among the nurse-led centres. The nature of homelessness meant that clients were presenting at a number of the centres for support. However, because there was no central access to medical information, a coordinated care plan could not be enacted. In 2005, a GP practice sent a proposal to the Health Authority to create an overarching network to unite the individual services. The most important element to this network was the introduction of an Internet-based computer service. The programme was to include GP software so that all clinics could hold their notes on a common database.

In response to this proposal, Safetynet was established. The organisation acts as the 'link-pin' between the nurse-led centres and various GP practices. It has a role in building the team dimension of the network, integrating the network through computerisation and telephone conferencing, developing best practice standards, and implementing a strategic plan. A key strength of the services provided by Safetynet is that medical needs are met, irrespective of whether or not the homeless person has a medical card.

Christina is a 28-year-old woman who is an undocumented resident in Ireland. Christina is homeless and is sleeping on a couch in a friend's accommodation. She developed a fever but was afraid to attend mainstream services for support for fear of being deported. Christina attended the Safetynet service where an assessment was carried out. Christina had a sexually transmitted viral infection (Hepatitis B) so she was provided with medication and given information on safe sex practices.

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Recently, Safetynet has begun to link with services in other parts of Ireland, especially the multi-disciplinary health team for homeless people in Cork city. In Dublin, Safetynet works closely with a range of specialist health and welfare services for homeless people, including:

- The Homeless Persons Unit that is staffed by Community Welfare Officers (CWO). The service is the first point-of-contact for most people when they become homeless. In addition to providing a placement and payment function, the CWO provides advice to people on a range of health and welfare services.
- The HSE's Healthlink Teams that were established in 2000 with the primary function of identifying and working with homeless people with complex health needs. The Teams link these people into appropriate services.
- The ACCESS Outreach Psychiatric Team that provides an assertive outreach service to homeless people with mental health needs and provides training and support to staff in homeless services.
- A dedicated dental service for homeless people that operates from two locations in Dublin. One is based in a local dental clinic and the other in a busy homeless day centre for homeless people.

The World Health Organization (1998) defines a network as "a grouping of individuals, organisations, and agencies organised on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust". According to this definition, given its structure, function, and aims, Safetynet is a network organisation. Consequently, it strives to:

- Promote information exchange and coordination.
- Build on shared knowledge and support learning.
- Increase the overall impact of interventions and develop innovative approaches in response to gaps and emerging needs.
- Make better use of limited financial and organisational resources.

Safetynet achieves a number of these key elements of network organisations. For example, in 2008 members of the Dublin Simon Rough Sleeper Team realised that after 5pm, a number of its clients were engaging in drug use but did not have access to clean needles. In response to this need, the team decided to establish a backpacking needle exchange initiative. The aim was to provide rough sleepers with clean needles and information on safe injecting. The Health Service Executive advised that the team would need clinical governance to establish the service. Consequently, Safetynet agreed to provide clinical governance for the backpacking needle exchange initiative. This example clearly illustrates how networking organisations can respond to gaps (lack of out of hours needle exchange provision) and use existing resources (Safetynet's ability to provide clinical governance) to develop innovative services (the development of a backpacking needle exchange initiative).

In 2007, the Safetynet programme offered medical support to over 6,500 people in over 12,000 contacts. The most common treatments included wound management (e.g. treatment of ulcers and abscesses), deep vein thrombosis management, chest infections, and vaccinations. Also in 2007, Safetynet engaged with the National Drug Treatment Centre and the Irish Methadone Implementation Committee to establish a methadone-prescribing programme for homeless drug users. Currently, approximately 16 people are part of Safetynet's methadone programme. Allowing people fast access to methadone can help reduce some of the risk elements associated with problematic intravenous drug use, including Hepatitis C infection, HIV, and skin problems.

Thomas is a 22-year-old male who injects heroin. He developed an abscess in his leg and attended the accident and emergency department for support. He left, however, before receiving medical intervention. When asked why he left, Thomas explained that he needed to leave to use heroin. Thomas referred himself to the Safetynet service where a nurse lanced the abscess and enquired about Thomas's drug use pattern. Thomas explained that he was injecting into the side of the abscess because he had a problem finding a vein. Over a number of weeks, the nurse worked with Thomas to support his move from intravenous heroin use to smoking heroin. Thomas explained that the smoking of heroin was "not holding him" and he would need to return to injecting. The nurse discussed the option of methadone maintenance but Thomas explained that he was on a waiting list for a methadone programme. The nurse referred Thomas to Safetynet's methadone programme where Thomas was successful in getting a place on the methadone programme. As a result, the abscess has healed and Thomas is no longer engaging in intravenous heroin use.

The future

Safetynet has been a necessary response to the health needs of a group of marginalised people who have great difficulty accessing mainstream health services. It cannot, however, be considered the ideal situation as it operates apart from the mainstream health care delivery system. In the future, it must become a part of that system. In addition to not covering all centres that homeless people attend, Safetynet is dependent on the personal commitment of a group of highly motivated GPs and other medical personnel. The long-term sustainability of the organisation is not, therefore, assured.

The transformation process within the HSE offers an opportunity to address some of these issues. Safetynet has a vital and important role to play in this process. As part of the national transformation, the primary care strategy Primary Care: A New Direction (2001) is being rolled out across the country. The strategy envisages a primary care system that is "available to all people regardless of who they are, where they live, or what health and social problems they may have." This involves the development of Primary Care Teams (PCT) to serve a population of approximately 7,000. These multidisciplinary teams will consist of GPs, nurses, social workers, occupational therapists and other specialists relevant to the needs of the area. All people in an area can register with their local PCT and the team will then act as a gateway to all other health services, including hospital services and services for mental health and addiction. Several of these teams will constitute a Primary and Social Care Network (PSCN), thus allowing the provision of additional specialist services when necessary.

As part of the development of these new structures, a national group within the HSE has been examining the particular issues of marginalised groups. The group has been addressing issues such as the fact that homeless people may not present to health services until they are in acute need, that the mobility of homeless patients may mean that they present to several different PCTs in a short space of time, that homeless people are likely to have a range of complex health needs when they do present to PCTs, and that these needs will be wider than mere health needs.

Therefore, to ensure the health needs of homeless people are adequately met by PCTs it will be necessary that these teams provide an outreach service to hostels and day centres, that systems are in place to ensure that when homeless people move they are dealt with by the PCT in the area in which they present and are not sent back to their original team, and that PCTs do not have the right to refuse people a service on the basis that they are homeless. The aim is to eliminate the need for a parallel system of care for homeless people.

So how will the government's on-going reform programme impact on Safetynet and other medical personnel currently providing a dedicated service to homeless people? The nurses and other medical personnel providing services in hostels and day centres will continue to provide services, but they will then be part of the local PCT or PSCN. In effect, they will be part of the outreach arm of the PCTs. This will ensure that the medical staff based in hostels and clinics can attend clinical case conferences and have access to the full range of services provided by PCTs for their clients. These specialist staff will also provide support and information to other members of the PCTs and the corresponding networks when homeless people present for a service.

The development of the new HSE structures presents an opportunity to reconfigure some of the existing specialist services to ensure the maximum benefit for homeless people. It is intended that the new primary care structure will be the first point-of-contact for the entire population when they have a medical need (other than an extreme emergency). In this context, in order to ensure equity, it is vital that homeless people and other marginalised groups access primary care services through the same 'front door' as the rest of the population.

Changing from a separate, specialised service to one in which homeless-specific and mainstream services are integrated will not be easy. In particular, it is vital to ensure that the transition process does not in any way further disadvantage homeless people. A range of issues needs to be addressed to ensure a more comprehensive and holistic approach to the health needs of homeless people:

- Respect and accommodation for the preferences of service users in relation to who provides a service to them and where.
- Retaining the benefits of the Safetynet computer system and expanding this in the new arrangements.

- Referrals into PCTs for first time homeless people and referrals back to PCTs for homeless people in prison or hospitals.
- Clinical governance for health staff employed by NGOs and working in hostels and day centres.
- Definition of the role of hostel key workers in the context of the rollout of care and case management and how these workers will link with PCTs.
- Development of protocols that recognise that some specialist staff, such as the Outreach Psychiatric Team for Homeless People, will be attached to a particular network while also having a remit wider than one specific network.

In many ways, a litmus test for the effectiveness of the new primary care strategy will be the extent to which separate specialised services for the homeless are still deemed necessary after the strategy is implemented.

Conclusion

An opportunity now presents itself to more closely integrate the work of Safetynet with mainstream health service provision and to ensure the learning of the Safetynet team is disseminated to Primary Care Teams and Networks. Nevertheless, it is extremely difficult to provide an effective health service to people so long as they remain homeless. The longer the period of homelessness, the greater the complexity of the health need. As part of the ongoing partnership process, health services must continue to engage with housing providers to ensure that long-term accommodation is provided at the earliest opportunity. Part of the role of specialised services will be to ensure that as people move out of homelessness they are linked to the appropriate PCT to ensure continuity of care. There is wide-ranging evidence that stable accommodation provides a much more effective setting to address the complex addiction, mental health and other health needs of homeless people (Culhane & Metraux 2008).

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CHAPTER 13

HEALTH AND HOMELESSNESS: THE CORK MODEL

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For most people in Ireland, accessing health care means going to see their general practitioner (GP) and, if required, being referred on to specialised services as appropriate. But doing so presumes we know where the GP surgery is, when it is open, if we need an appointment, in which case we would need to know the telephone number, how long we may have to wait before being seen, how much the services will cost, and how to go to a pharmacy if we are given a prescription.

Now consider 32-year-old John. He arrived today in Cork city because he was recently evicted from his flat, and as there is no emergency homeless hostel in the town where he lived, he was advised to come to Cork. But he has never been to Cork before, he has an alcohol problem, a chest condition and he suffers from depression having had an admission to hospital following an overdose. He is a smoker. He recently fell while intoxicated and suffered a laceration to his right leg, which is now infected. He was on inhalers for his chest, antibiotics for his leg and antidepressants for his depression. But his inhalers and antibiotics were cleared out of the old flat before he could get to them and he stopped taking the antidepressants because the container said not to take them with alcohol. His medical card is out of date and he does not have any money.

John met some people at the bus station who told him how to get to the nearby Simon Hostel but the hostel was full, so he got a blanket and slept near a bridge in the city. He returns to the hostel every night to see if a bed becomes available and he uses the Simon day centre in the morning to wash and get something to eat. John knows he needs to see a doctor; his options, however, are limited. He can go to the Accident and Emergency departments of the Mercy or South Infirmity hospitals (city centre based emergency departments) if he knows where they are located or he can apply for a medical card.

This chapter examines John's story primarily from a clinician's perspective, supplemented by discussion of the housing, homelessness and policy contexts. The chapter outlines the housing and homelessness background, and then the context within which the Cork City Adult Multidisciplinary Team (MDT) arose, the needs to which it responded, the experience gained during the time the team has been in operation, and the rationale for a tailored site-specific health service for homeless persons.

Housing in Cork city

Cork is Ireland's second largest city. Within the city boundaries lives a population of 119,000 people, with a further 153,000 persons in the 'metropolitan ring' (CSO 2006, Cork Planning Authorities 2007). As elsewhere in Ireland, a wide and interlinking set of factors – both structural, intermediate, and individual – relating to the tenure system, income maintenance criteria, housing benefit policies, employment opportunities, discharge policies, through to individual factors shape the precise nature of presented need in relation to health and homelessness.

The proportion of rental dwellings in Cork city is higher than the national figure, with one-fifth (20 percent) of dwellings classed as social rented and 15.4 percent as private rented. While owner occupied housing is the dominant tenure type, providing housing for three-fifths (60 percent) of households in the city, this is down from the 63 percent in 2002 – see Figure.1 .

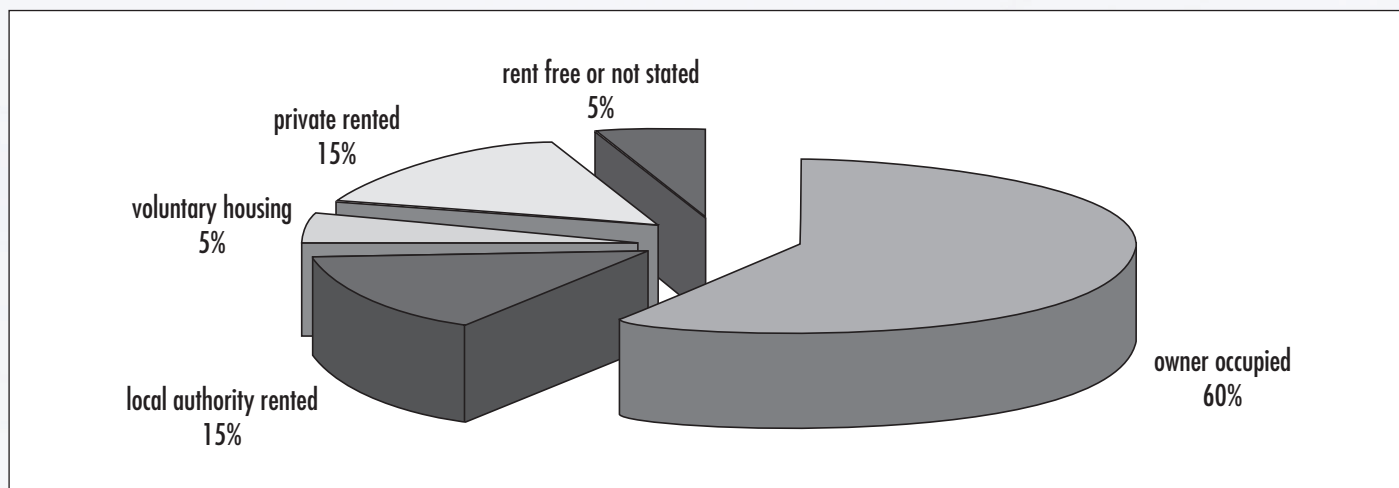


Figure 1: Cork City households by tenure 2006
Source: Finnerty & O'Connell (2006)

Such tenure patterns in urban areas are found elsewhere in Ireland and abroad, and are principally due to higher housing costs in these areas, depressing rates of owner occupation and increasing need for private and social renting. While the level of social housing is sometimes used as an indicator of social disadvantage (Edwards & Linehan 2003), this should rather be seen as evidence of a successful response by local housing authorities to social housing need.

Historically, Irish public policy responses to social housing need exhibit cyclical patterns (Finnerty 2002). Currently, despite the high percentage of social housing tenure in Cork city relative to national or urban shares, the waiting list for social housing in Cork city has grown in recent years (Finnerty & O'Connell 2006). Within the private rented sector, a substantial proportion access rent supplement, a housing income support for households in receipt of social welfare payment. While the Residential Tenancies Act, 2004 legislates for improved security of tenure, many loopholes in this legislation mean that 'John' may be evicted summarily, with or without having violated the terms of the tenancy.

Additionally, social housing allocation to homeless households, particularly single person households, face issues of unavailability of supply of single person units, lack of allocations in suitable areas, often poor levels of tenancy supports, and issues of estate management (Lawless & Fitzgerald 2005, Bergin et al. 2005, Finnerty & O'Connell 2005, 2006). Access to the private rented sector may also be problematic, given the discretionary role of private landlords in allocating accommodation to households in receipt of rent supplement in Cork (Finnerty 2004, Kiely 2005). The patchy implementation of the discharge strategies (under the Homeless Preventative Strategy) for those leaving institutional care (prisons, young persons' care, mental health facilities) also poses problems (Lawless & Fitzgerald 2005, Fitzpatrick Associates 2006). The result is that some of this vulnerable population end up roofless or homeless, and present to the MDT, although quantification of this sub-population remains under-researched (Lawless & Fitzgerald 2005, O'Sullivan 2005, Fitzpatrick Associates 2006).

Homelessness policies and levels of homelessness in Cork City

As noted elsewhere in this collection, the Homeless Integrated Strategy requires the health authorities to provide for the health needs of homeless persons, and in the context of Objective 3 of the Cork City Homeless Strategy, 'to continue to develop appropriate health and welfare services for all homeless people' (Cork City Council 2005: 16).

Measurement of homelessness in Cork, as elsewhere, is subject to much controversy. The official triennial count in Cork city on a date in March 2005 recorded a figure of 341 homeless households.

Health services for homeless persons prior to establishment of the Multidisciplinary Team

Prior to March 2002, a public health nurse who had the St. Vincent de Paul and Simon Community Hostels located in the area for which she was responsible provided health care to people experiencing homelessness. The workers in the hostels would inform her of health concerns and she would then see the patient and liaise with their GP or the hospital as appropriate.

The Community Welfare Officers (CWOs) were often the first port of call for people experiencing homelessness and the CWOs were often confronted with people who they suspected were physically or mentally unwell and required medical assessment. They would then try to have the patients seen by the relevant service.

A recurrent problem was a transient homeless population that was new to Cork City and consequently not known to a local GP. A large proportion of the people experiencing homelessness in Cork at that time did not have a medical card despite the fact they were entitled to have one, a fact borne out by Laura Frost who found in her report in 2000 that 29 percent of homeless people surveyed did not have a medical card. The people in this situation trying to access health care were then dependent on the good will of the GPs based in the centre of the city and the Accident and Emergency Departments of the hospital located in the inner city. Both these groups of health care providers were already overworked and cared for an above-average number of people experiencing some form of social deprivation. This disadvantage presents itself in a higher proportion of morbidity and mortality that is endemic among the homeless, as was shown by studies carried out by Bines in the UK in 1997 and the RCSI et al. in Dublin in 2000. Higher mortality and social deprivation bring with it a greater workload for the GP.

Challenges obtaining a medical card

To apply for a medical card John needs to know from where to get the application form, to complete it despite his poor literacy skills, to find a GP and ask the GP to take him on as a patient. If the GP agrees to take him on, the GP will stamp the application form and John will then have to bring it back to the health board and wait for his card be posted out to him.

This process is not very complicated for most people, but for John, his main worries are *Where will I sleep tonight? How will I get money and where will I get my next drink? Can I really wait in that waiting room when the small child says he will not sit next to that man because he is smelly?* Furthermore, when John does see a doctor he must receive a private prescription as the doctor cannot write a medical card prescription for him without a medical card number. John, however, does not have the money to pay for a private prescription.

Any person experiencing homelessness in Ireland is entitled to a medical card and some people even have more than one card from different Health Service Executive (HSE) areas. But a medical card does not necessarily guarantee access to a GP. While homeless people in Ireland are entitled to receive social welfare payments, identification and an address are required for registration.

John has lost his birth certificate and as he was born in Scotland to Irish parents, he has to write to Glasgow to get a new one sent in the post. But because John has only recently arrived in Cork, he does not have an address. He survives by begging on St. Patrick's Bridge but was assaulted last night on his return to the Simon Hostel. The money he collected during the day was stolen from him.

One specific GP or officer of the HSE cannot alone help John. From a practical point-of-view, it takes more than one person and more than one clinical or social speciality to deal with the various problems that John encounters in his life.

The MDT and the Adult Homeless Integrated Service

In March 2002 the Adult Homeless Integrated Service commenced work in Cork city. This is a partnership between the statutory sector, consisting of the City Council and the HSE South (formerly the Southern Health Board), and the voluntary sector, including the Simon Community Hostel and Day Centre and the St. Vincent de

Paul Hostel in Cork City. The Adult Homeless Multidisciplinary Team (MDT) is the part of the Integrated Service that provides health services from the Health Service Executive in locations provided by the voluntary sector. For easy access to the surgeries and clinics these are located over the Simon Day Centre in Andersons Quay for people staying in the Simon Emergency Shelter and for rough sleepers using the Day Centre. The Surgery in the St. Vincent de Paul Hostel is located in a specially adapted portacabin on the grounds of the hostel in Anglesea Terrace. It has been agreed with both service providers that service users from both hostels and rough sleepers can access health services in either location regardless of where they presently happen to be staying.

The MDT consists of a full-time public health nurse, a part-time registered nurse, two full-time community mental health nurses, a part-time addiction counsellor provided by Arbour House Addiction Services, a part-time Health Promotion Officer provided by the Health Promotion Department, a part-time clinical psychologist, a part-time consultant psychiatrist and a part-time GP. In addition to the clinical specialities, the MDT consists of four CWOs located in the Homeless Persons Unit in Drinan Street. The incorporation of clinical and welfare aspects in the care of the person experiencing homelessness into the MDT has been a great practical success in the day-to-day functioning of the team.

Services provided by the MDT

As is the case for the general community-based population in Ireland, access to health care for homeless people in Cork is centred on the GP and the public health nurse. The public health nurse sees patients every day in the hostels where she triages them according to their symptoms and deals with their problems as appropriate. This may involve doing dressings or referring them to their own GP or the GP attached to the homeless team. Sometimes it may also mean sending the patient on to Accident and Emergency. The public health nurse liaises with the hospital outpatient departments and arranges appointments for patients who may have lost or missed their appointments. She arranges appointments with dentists, chiropodists and community physiotherapists and arranges the delivery of medical aids as needed. She also refers people to the CWOs if they are not in receipt of social welfare payments or do not have a medical card.

Additionally, a GP holds five clinics per week with either the public health nurse or the community registered nurse. Three clinics are held over the day centre in the Simon Community and two clinics are held in the portacabin on the grounds of the St. Vincent de Paul hostel. Patients staying in the hostels, rough sleepers or sofa surfers (homeless people staying with friends or family) using the day centre facilities can self refer or be referred by hostel staff. Referrals also come from within the MDT, from the local hospitals when patients are being discharged and from prisons when people are being released. We also get referrals from other GPs and from social workers.

Accessing entitlements

When a new patient arrives, they are advised that they are entitled to a medical card. Application forms are available in the hostels and from the CWOs based in Drinan Street. If required, the patient is assisted by hostel project workers to complete the form and given a list of GPs who are geographically near the hostels. Realistically, they can apply to any GP with a General Medical Services (GMS) number to take them on as a patient if the GP's GMS list is open to taking on new patients, but practically, the city centre GPs are the ones most frequented by homeless patients. Some patients will require a project worker to attend the surgery with them. Once the GP has stamped the form and accepted the patient on to his or her GMS list the CWO can obtain a medical card number within 24 hours.

While this process has greatly simplified the medical card application process for people experiencing homelessness in Cork city, we still have some people who are not able to complete this process. Initially this was a problem as we were seeing patients who did not have a medical card and were not able to prescribe for them. The problem was amplified because our GP practice did not have a GMS number and consequently we did not have GMS prescription pads. This issue was highlighted at a MDT meeting by the GP and a solution was found by the southern health board. A GMS number was allocated to the GP for prescribing only and GMS prescription pads were provided. Furthermore, a generic medical card number was provided and this is used to prescribe for people who do not have a medical card. This generic medical card number can now be used to see patients out of hours in the GP out-of-hours cooperative, Southdoc, which provides out of hours GP cover for Cork city.

Accessing the Mental Health Team

Access to the psychiatrist is by referral from the GP. The psychiatrist also receives referrals from other GPs who have homeless people registered with them and also from the psychiatric units based at St. Michaels Mercy University Hospital, GF based at Cork University Hospital and St. Stephens based at Sarsfield Court. The psychiatrist holds her clinics in the portacabin in St. Vincent's and over the day centre in the Simon community. She can refer to the clinical psychologist and the two community mental health nurses as appropriate. The psychiatrist sees patients on an outpatient basis and any patient requiring emergency admission is admitted to one of the local psychiatric units depending on the sector in which the patient was seen. All team members can refer to the addiction counsellor and patients can also self refer or are referred by hostel staff, although this process of referral is now under review. The clinical psychologist receives referrals from the psychiatrist only.

Table 1: Statistical overview of patients, 2002-March 2008

	St. Vincent de Paul Hostel	Simon Community	TOTAL
Consultations	2678	7010	9688
Patients seen			
Males	571	559	1130
Females	13	117	130
Total	584	676	1260
Age of patients	18-86 years, mean of 39.8 years	17-69 years, mean of 34.8 years	17-86 years, mean of 37.1 years
Length of time homeless	-	-	1 day through 44 years
Mental health problems	229 (11%)	385 (57%)	614 (49%)
Drug and/ or alcohol addiction	250 (43%)	433 (64%)	683 (54%)
Chest problems (asthma, bronchitis, Chronic Obstructive Airways Disease, tuberculosis and recurrent chest infections)	67 (11%)	178 (26%)	245 (30%)

Profile of service users

The morbidity and mortality of the homeless patients are appalling. Table 1 summarises the most frequent conditions of the patient load. Since we began providing care in 2002, 48 patients have died. The average age at the time of death was 46 years. 73 percent of the deceased had a history of addiction problems and 63 percent had a history of mental health problems.

Until 2007, practically all the people experiencing homelessness who accessed health care through the multidisciplinary team originated from either the islands of Ireland or Britain. At the beginning of 2007, however, we saw a significant change in this demographic, with an increase in the number of people accessing the service who originated from one of the new EU12 accession states – 263 consultations in 2007 involved this group alone. Most of these patients' medical histories and presenting complaints are similar to those of the population of homeless people prior to the accession of the EU12 countries.

Nevertheless, the new patient demographic has led to a significant change in the way we work, with some consultations being translated by patients' friends, other service users or project workers or volunteers. We have had some clinics where English was not the first language of any of the patients seen on that day. This leads to

many practical problems in trying to take a history from the patient, explaining physical examinations and investigations and making sure that the treatments available and prescribed are fully understood. Although there has been great support from the project workers and volunteers who act as translators, there is always the intrusion in confidentiality when a third person acts as translator. It can also be uncomfortable for the patient and translator when questions of an intimate nature are asked. The project worker may also have other roles within the service, which may lead to conflict or blurring of boundaries when they act as translators. Patients may not be as willing to disclose certain problems with a third party present. All this leads to a more stressful, a less satisfactory and a longer consultation.

Most of these people do not fulfil the two year requirement for habitual residency and are, therefore, not entitled to social welfare payments or a medical card. This has led to many practical problems in trying to access appropriate services for this group. At present Cork City Council is funding a survey on the origins and problems of this population.

After six years working in the service, members of the MDT can usually tell if someone is homeless, is at high risk of becoming homeless, or has been homeless in the past by how they present and the nature of their medical complaints. A very small number used the service even though they were not homeless. These were people who had heard there was a doctor available in the Simon Day Centre and either presented regardless or were unaware the service was not for them.

Where we fit in

The Cork Adult Homeless Integrated Service multidisciplinary team model works as a conduit between a specialist service for homeless people and the generic primary care service. We provide basic medical care for people who would otherwise have difficulty accessing it, but the aim is to register patients with a GP and assist them in navigating the process of seeing the GP on a regular basis. Thus, once a patient is seen, we try not to hold on to them. We encourage them to establish a relationship with a GP who has a contract with the General Medical Services, which also makes it possible for them to obtain a medical card.

Some patients may continue or intermittently go through difficult times and relapse and they may come back to us. If this occurs then communication between the homeless team and the patient's own GP is extremely important. The team could not continue to operate without the continued support and close cooperation of the GPs, pharmacists and hospitals in the city of Cork.

The future for the team

In today's economic climate the future of the Cork model will depend on its perceived value for money by its statutory and voluntary sector funders. In a time of economic restriction any service that is seen to be a waste of money or duplicated will be under threat. An evaluation of the service will not only require consideration of the MDT's success, but definition of what constitutes a successful outcome. In a medical model, evaluation of outcomes may look at symptom reduction, admission reduction and proper use of resources. From our own data, we know a lot of patients regularly attend the service. It would seem we are not having much success in ending their homelessness. But outcome measures need to recognise the context of the lives of the people who the service is trying to help, where they are coming from, where they are now and where they hope to ultimately be.

It is imperative that the continuity of the work done by the team is not threatened by the loss of any member of the team. In the current financial climate should a team member retire or leave for other reasons there is a concern, whether real or imaginary, that they may not be replaced. To avoid the team being personality driven we need stable frameworks for working and permanent structures in place so that the work of the team may continue regardless of who occupies the posts within the team.

The development of primary care teams is an acknowledgment of the success of the Cork MDT way of working. Primary care teams and MDTs are a coming together of various professionals to work in an integrated way to provide the best social care and health care. They are not mutually exclusive. The provision of primary care

teams should not be to the detriment of the advances made in provision of health care to vulnerable people such as people experiencing homelessness. They both need to coexist, work together and use each other's resources to the betterment of the patient.

As the team becomes better known among health care providers within the city of Cork, the Gardai, and the business community of Cork, we can use this opportunity to advocate on behalf of people experiencing homelessness. We can liaise with the hospital outpatient departments and Accident and Emergency to provide better access to the care our patients require.

We will be able to apply developments in other parts of the country to improve the service we provide. There is no point in reinventing the wheel when we see structures in other cities that we can implement in Cork. This year we expect to introduce to the city the Safetynet system, developed by Dr. Austin O'Carroll in Dublin, subject (inevitably) to funding being available. Safetynet is a computer system provided at various hostels around the city. If a patient has been seen in one of the hostels and their medical details stored on the system, they can then be followed up at a different hostel if they have moved and by a different healthcare professional. This will allow for better continuity of care and better follow up.

As a team we have to accept our limitations and work within the system as it currently exists. We, as a team, cannot provide accommodation or stop people accessing substandard, inappropriate accommodation. We know that failure to obtain these basic needs can have a detrimental effect on people's health but as health care professionals we have no realistic impact on them. What we can try to do is highlight these problems, our experiences and possible solutions as we see them to the relevant organisations.

We are confronted repeatedly with requests for medication, including benzodiazepines, opiates and hypnotics, that we may not feel is always appropriate to prescribe. This can sometimes lead to confrontation, exhibited in occasional verbal outbursts and (thankfully very rarely) physical threats when these requests are refused. The challenge here is to try and maintain or establish a relationship with the patient by highlighting what is available and possible within the service and within an ethical, legal, healthy and realistic prescribing policy.

We are here as a team to help people like John gain access to basic medical care. We try to achieve this by minimising or removing the perceived or real obstacles to them obtaining basic medical care. We facilitate their engagement with the Generic/General Medical Services and we accept that sometimes they will not be able to do this. We try to show them that other choices are possible other than the road they may have been travelling to date when and where they are ready to make those changes. Access to basic medical care will be provided no matter what choices the patients such as John may make.

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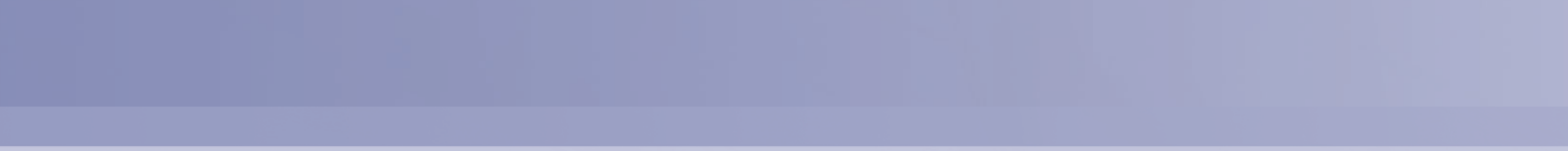
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