A Step in the Right Direction

An Evaluation of the Fáiltiú information and Advice Service

by Caroline Corr

(This report was written and compiled in 2001).

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- Half of the respondents were early school leavers while 53% had no formal qualifications.
- 75% were unemployed and female respondents and older people were more likely to be unemployed.
- 65% had been in prison although of those who reported spending time in prison, 92% were male.

Experiences of homelessness

- Two-thirds of the clients had earlier experiences of homelessness. 42% of the sample had become homeless when they were 16 years old or younger.
- Male respondents tended to become homeless at a younger age than female respondents, were more likely to have previous experience of homelessness and had been homeless on average twice as many times as female respondents.
- The mean length of time homeless is 2.88 years. Almost a third of the respondents (31%) reported that their longest period of homelessness was less than one year.
- The most frequently reported life event that preceded homelessness was family conflict, followed by drug problems and alcohol problems.

Alcohol Consumption

- Overall 61% of the sample were regular drinkers (i.e. drank alcohol in the last month) and female respondents were more likely to be regular drinkers.
- Half of the sample drank alcohol in a typical week, 35% of whom consumed more than the recommended weekly limits of alcohol.
- More than a third of the sample (35%) were categorised as fairly heavy - very heavy drinkers. Over a fifth were very heavy drinkers (22%).

Drug Use

- The vast majority of those who reported lifetime use of drugs (n = 29, 85%) also reported current use of drugs (i.e. in the last 4 weeks).
- Among the current users, a substantial number reported using prescribed methadone as their primary drug of use (n = 13, 45%) while a further 31% (n = 9) reported using heroin. Another three respondents reported that cannabis (8%) was their main drug of use. One respondent respectively reported their primary drug was street methadone, cocaine, Dalmane or sleeping tablets.
- Overall, 14 people (37% of the total sample) were taking heroin, 9 as their primary drug of use and 5 as their secondary drug of use. Among those who took heroin, 86% (n = 12) were injecting.
- 63% of the total sample were polydrug users (excluding alcohol).
- 86% (n = 31) of those who had used drugs reported injecting drugs at some time during their drug using career and 16 (44%) were currently injecting.
- A substantial proportion of those who injected started injecting between 15 and 19 years of age (n = 12, 41%).
- More than a third of those who had been injecting (n = 11, 38%), were injecting for 10 years or more.

- Female clients and younger clients were more likely to report current use of drugs and more likely to be polydrug users.
- ® Male respondents were more likely to report initiating drug use at an earlier age, and reported injecting careers twice as long as female clients.

Physical Health

- Almost half the respondents (47%) perceived their health as poor/very poor.
- All of the respondents reported suffering from one or more physical complaints, while two-thirds were suffering from 5 or more complaints.
- The most common complaints were dental problems, headaches, colds and flu and Hepatitis C.
- Less than half the sample had been vaccinated against Hepatitis B (47%).
- Only one female client (13%) had undergone a smear test in the last 3 months while no female client had undergone a breast examination in the last three months.

Psychological Well-being

- The levels of reported mental health complaints were extremely high with 90% of the respondents having felt depressed in the 3 months prior to interview.
- Women were more likely to report mental health complaints.
- 42% of the respondents had been diagnosed as suffering from a psychiatric illness.
- Only 11% were in contact with psychiatric services. Although, in the past over a third had been admitted to a psychiatric hospital (35%). The main reasons were depression, nervous breakdown or alcohol dependency.

Health Services

- Less than half the clients reported having a medical card. Male clients and older people were more likely to have medical cards.
- Among those who have a medical card, 22% applied through the Fáiltiú Information and Advice Service.
- Analysis revealed that clients were less likely to contact health services if they were not in possession of a medical card.
- All of the female respondents (100%) and the majority of males respondents (87%) had been in contact with health services in the 3 months prior to interview.

Evaluation Data

A total of 40 service users completed the evaluation of the Information and Advice Service. Their views and opinions of the Service are summarised below.

Evaluation of the Information and Advice Service

- The majority of service users (70%) preferred to find out information by asking another person.
- Almost two-thirds of service users (60%) received information on housing, social welfare and health issues from the Fáiltiú Information and Advice Service.
- Younger clients and female clients were more likely to use the Information and Advice Service.

Pieces of the Jigsaw

- 55% of service users heard about the Failtiu Information and Advice Service through their friends.

- 98% of clients asked to use the telephone at the Information and Advice Service to access the Homeless Person's Unit and similar agencies. Furthermore, over half the clients used the Service for information on emergency accommodation, social welfare, health issues and drug issues.

- The vast majority (90%) of service users did not report any difficulty accessing information.

- Barriers to requesting information included repeating requests several times to different staff members, queuing to talk to staff, lack of available rooms to discuss information, staff were too busy or there was not enough time.

- Clients requested more information on housing, applying for housing through the City Council, private rented accommodation, services for rough sleepers, drug treatment, medical and counselling services.

- Almost all the clients (93%) sought the establishment of a key worker system.[2]

- The majority of respondents (62%) felt that contact with workers could be improved.

- Almost two-thirds (60%) of the service users had taken leaflets and all of them reported that they were useful.

- Overall the clients were very satisfied with the accuracy, presentation, relevancy and clarity of the information.

- The vast majority of service users also rated the staff highly on their ability to listen, their friendliness, approachability and ability to communicate clearly.

- Service users reported they like to come to Failtiu to talk to staff and their friends, because the staff were "friendly" and "helpful" and because "of the atmosphere" and it was "somewhere to go".

- Three-quarters of the clients felt that the Failtiu Information and Advice Service could be improved

Recommendations

While the results of the evaluation were positive in relation to the delivery of the Fáiltiú Information and Advice Service, there is a need for changes in the internal structures and external relationships of the Service. These changes will ensure that the needs of service users are met.

- Fáiltiú staff need to be more proactive in making clients aware of the Information and Advice Service. Information needs to be disseminated from relevant media sources. Moreover, the information provided needs to be accessible to those with literary problems and readily available. Consideration should be give to introducing a touchscreen information database in Fáiltiú, a peer support group and reviewing the space to maximise the number of rooms for contact work.

- The results showed that the Information and Advice Service would be more effective if staff members specialised in providing information on different areas. A professional key worker system needs to be established and an integral part of the key worker role should be to act as

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[2] Key working involves providing consistent support to individual clients and preventing vulnerable people who use the service from slipping through the net. If used properly, it can help issues be resolved more effectively.

advocates for individual service users. For this to work effectively, Fáiltiú staff should participate in on-going training.

● Further information is needed on different housing options, the criminal justice system, training and educational programmes, family mediation services, alcohol and drug services, and health and psychiatric services.'

● Most importantly, while the Fáiltiú Information and Advice Service have links with other agencies through the Homeless Network and the Homeless Agency, it needs to establish stronger links with other voluntary and community organisations, statutory services and health services.

Introduction

This chapter outlines the background and objectives of the study. This study was supported by the Homeless Agency[3] allowing Merchants Quay Ireland to carry out an evaluation of the Information and Advice Service, which is part of the Fáiltiú Resource Centre.

1.1 Background to the Study

This evaluation focuses on the Fáiltiú Information and Advice Service. This service aims to provide accurate, comprehensive and user-friendly information for homeless people in Dublin. The goals of the Information and Advice Service are to ensure that homeless people, or those at risk of homelessness, receive full information on their rights, are offered a range of options available to resolve their housing difficulties and have seamless access to other relevant services. Work done within this service includes the following:

- proactive assessment of clients' information needs
- advice and information on health, social welfare, emergency accommodation, housing and any other issues
- liaison and referral to outside agencies
- assistance with form filling
- production and distribution of information materials of relevance to homeless persons.

Since its inception, Fáiltiú has been providing information and advice. An Information Officer was initially employed in 1999, funded by the National Social Services Board (now Comhairle). The Information Officer is responsible for the co-ordination of the Information and Advice Service and for integrating this Service with other services at Fáiltiú and the Merchants Quay Project. An important part of the post is to provide information resources to staff members. The Information Officer also approaches service users in a non-intrusive and sensitive fashion and informally assesses their current situation with regard to rights and entitlements. Information, advice and advocacy are provided where necessary. Furthermore, the Information Officer provides a comprehensive range of information materials, which are accurate, relevant and user-friendly. Leaflets are developed in conjunction with the Fáiltiú Arts Group and Merchants Quay Project's service users. Moreover, the Information Officer provides training for volunteers, CE workers and full-time staff including training on the use of the NSSB/Comhairle computerised Information Database. This position is now funded by the Homeless Agency.

In a review of the Fáiltiú Resource Centre in 1998, 81% of the service users rated the Information and Advice Service as being good or very good. An even higher percentage, 82%, said that the information provided had been clear or clear. However, just 55% found the information to be useful or very useful with 36% saying it was of limited use. Since this evaluation, Fáiltiú has developed significantly and considerable effort has been

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[3] As part of *Homelessness - An Integrated Strategy* (May, 2000), the Homeless Agency was established to lead the implementation of the Government's new Action Plan to combat homelessness and to manage the delivery of services to people who are homeless in Dublin.

channelled into integrating the Information and Advice Service with other services in Fáiltiú. Therefore, it was decided to carry out a more in-depth evaluation on how effective this move has been. It is generally considered that internal evaluation is an important element in good management (Murray *et al.,* 1994). The purpose of an evaluation is not only to assess the value of a service but also to assist in its improvement (Robson, 1998).

Providing information to homeless people is important for a number of different reasons. According to Bourdieu (1986), social power in society is composed of different forms of capital such as economic, cultural, social and symbolic capital. Cultural capital refers to various types of knowledge, which are learnt explicitly, in formal education and tacitly, through family, work and social contacts. Homeless people are excluded from many of these important sources of informal learning. The contacts and information provided by services like the Fáiltiú Information and Advice Service enable homeless people to cope better with their everyday needs. The marginalisation of homeless people is reinforced by lack of information, education, skills and confidence (Narayan, *et al.,* 2000). This is due to limited personal capability, including physical isolation, being cut off from the powerful and wealthy, lack of access to media and limited schooling (Narayan, *et al.,* 2000). Narayan *et al.* (2000) found in their study, carried out with 20,000 socially excluded people, that lack of information put them at a disadvantage in their dealings with public agencies, NGOs, employers, traders and lenders. Another form of deprivation they noted was not knowing about services, rights and meetings, or about how to gain access to them (Narayan *et al,* 2000).

Improving access to advice and information is an important component of *Shaping the Future,* (Homeless Agency, 2001), the new action plan on homelessness. This is because the Homeless Agency (2001) believes that information and advice can prevent homelessness by helping people who are imminently threatened with homelessness to explore their options and make informed choices. Furthermore, information and advice can prevent crisis homelessness from becoming a long-term situation. The Homeless Agency (2001) feel that information and advice services have a key role to play in the continuum of services for homeless people by enabling them to access appropriate services and entitlements and make choices about alternatives at all stages during their homelessness.

1.2 Objectives of the Study

The objectives of the study are as follows:

- to assess the information needs and aspirations of service users at the Failtiu Information and Advice Service;
- to establish how effectively these are being met;
- to identify strengths and gaps in the Fáiltiú Information and Advice Service; and
- to look at how the Fáiltiú Information and Advice Service can be developed and improved

This report aims to evaluate the Fáiltiú Information and Advice Service in the context of service needs of homeless people. In **Chapter Two** both national and international literature on homelessness and homeless services is analysed. **Chapter Three** outlines the research methods employed in carrying out the research. **Chapters Four, Five** and **Six** present an analysis of the quantitative and qualitative data collected through the research. Chapter Four analyses the data collected from the 115 service users who completed the screening questionnaire, during the weeks of 12th February to 21st March 2001. Chapter Five examines the socio-demographic profile of service users accessing the Fáiltiú Information and Advice Service. Finally Chapter Six presents an in-depth analysis of the evaluation of the Fáiltiú Information and Advice Service. The report concludes with **Chapter Seven** which presents some conclusions and recommendations.

Literature Review

In this Chapter literature on homelessness is reviewed. The first section aims to define homelessness and looks at its extent. The characteristics of homeless people are then examined. The next section outlines Irish social policy in relation to homelessness. Following this section, services for homelessness people are examined and gaps in service provision are identified.

2.1 Defining Homelessness

There are various definitions of homelessness, which pose a problem in identifying an all-inclusive definition. The official definition of homelessness in Ireland is given in the Housing Act, 1988 as:

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

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

b) he is living in a hospital, county home, night shelter or other such institution and is so living because he has no accommodation.

This definition includes people living in temporary, insecure accommodation, people living in emergency accommodation and hostels/health board accommodation, or more generally all those on the housing list, rough sleepers and victims of domestic violence. However, the definition excludes the 'hidden homeless' (i.e. those living in insecure accommodation) and those at risk of homelessness. Houghton and Hickey (2001) point out that those at risk of homelessness should not be ignored as many people experience homelessness periodically. Nevertheless, the Irish definition is broader than that of Britain, which excludes single homeless people, who are not viewed as 'vulnerable'.

Definitions of homelessness are informed by different theoretical explanations. Structural explanations of homelessness take into account broader social and economic factors such as the role of the housing market and the availability of housing (Neale, 1997). Therefore this model requires interventions on a broad societal scale including provision of temporary or permanent housing. A second explanation of homelessness is the individual theory which considers that homeless persons are responsible for their status (Neale, 1997). This 'victim blaming' response requires only minimalist action, on behalf of the State, such as the provision of very basic accommodation (Neale, 1997). Furthermore, the individual response, may also explain homelessness as a result of personal failure or inadequacy, which means that these individuals are in need of humanitarian assistance (Neale, 1997).

These two explanations are related to the notions of 'deserving' and 'undeserving' (Neale, 1997). Where homelessness is considered a result of structural causes, homeless people are often deemed 'deserving' of assistance (Neale, 1997). Conversely, where individuals are considered responsible for their situation, they are deemed 'undeserving' of support (Neale, 1997).

Neale (1997) would argue that explanations of homelessness are not as simplistic as those discussed above. Other theories on homelessness have been put forward by writers such as Watson and Austerberry (1986)

which critique access to housing, housing design and the meaning of the home or homelessness from feminist perspective. However Neale (1997) dismissed these theories as they categorised homeless women together as a homogenous group, ignoring the diversity of women's experiences. Neale (1997) proposes 'more comprehensive theoretical understanding of homelessness which includes all people, regardless gender or other personal differences' (42). Feminists have now begun to examine how 'women's lives a structured by public factors but without constructing women as homogenous, powerless, unthinking unquestioning victims, and, hence, denying their agency' (Neale, 1997: 42). These ideas have been used conceptualise new post-structuralist theories.

Neale (1992) argues that homelessness is better understood within a post-structuralist paradigm, which reject many of the dualisms often cited in discussions on homelessness (such as male/female, public/private structure/agency, deserving/not deserving etc.). Post-structuralist theory would propose that there is no one single oppressive force or no single solution to homelessness (Neale, 1997). There is now a general consensus among commentators that homelessness is the product of a multitude of factors, operating at local, national and global levels (Marsh and Kennett, 1999). Neale (1997) believes that these theories should be used conjunction with Giddens' concept of 'structuration'. This theory states that 'society does not determine individual behaviour, nor do individuals simply create society. 'Structure' and 'action' (agency) are rather intimately related and neither can exist independently of the other' (Neale, 1997: 47). Therefore which homeless people are social agents in their own right they are also constrained in certain ways. That is to say while power in society is concentrated in the hands of the state, institutions and individuals, homeless people can resist at a local level either by protesting at hostel conditions, or by objecting to how different individuals are constructed in policy discourses, or by disapproving of the social practices of housing officials are developers (Watson, 1999). In Ireland, a new 'voice project' has been established which provides opportunity for people who are homeless to speak out about their experiences and inform the development of policy are service responses (Homeless Agency, 2002). Possible models of empowerment include consultation through focus groups, a complaints procedure, policy forums, user forums, self advocacy groups and speak out even for people who are homeless (Homeless Agency, 2002).

2.2 Extent of Homelessness

It is difficult to obtain accurate figures for the number of homeless people in Ireland or Dublin. This is part due to the fact that the homeless population is a mobile, transient group. Furthermore, homeless people do not always register with a GP or appear on electoral registers or social services lists. Some even avoid outreach teams, shelters and day centres targeted at homeless people (Warnes and Crane, 2000). Therefore counts of homeless people often indicate only partial evidence of the problem (Warnes and Crane, 2000).

The figures that are available in Ireland indicate a continual increase in the number of homeless people although comparison is difficult due to methodological differences. Section 9 of the Housing Act, 1996 requires housing authorities to undertake periodic assessments of housing needs. The 1996 assessment, whit was based on a traditional format with the count taking place on one single night, indicated that there we: 2,501 homeless persons throughout the country. In 1999, a broader definition of homelessness was used order to include all elements of homelessness according to the Housing Act, 1988. This assessment found th there were 5,234 homeless persons. This was more than twice the figure of any previous estimate. The 19!: assessment in Dublin, Kildare and Wicklow showed an increase to 2,900 homeless adults and almost 1,000 dependent homeless children (Williams and O'Connor, 1999). In 2002 the number of homeless adult increased slightly to 2,920 while the number of homeless children increased to 1,140 (Williams and Gorb 2002). There was, however, a larger increase among rough sleepers. The rough-sleeper count found i increase of 13% in the number of people sleeping on the streets from 1999 to 2002 from 275 to 31 Nevertheless, these figures reveal prevalence of homelessness during one specific week in Ireland but they c not represent the incidence of new cases of homelessness in a given year. Therefore, as Houghton and Hickt (2001: 8) point out, 'it remains a rather crude and sterile measure', which substantially underestimates the the extent of homelessness.

The most comprehensive counts of rough sleepers in Dublin have been carried out by the Simon Community in conjunction with Focus Ireland and Dublin City Council. It is difficult to measure the number of people

eping rough as they tend to be mobile and spend periods on and off the streets (Pleace *et al,* 1997). The
>st recent count of rough sleepers in central Dublin during the week of 15th to 21st October 2000 found 202
rsons sleeping rough. This represents an increase of 60% on the street count of 8th to 14th December 1997
i a 36% increase on the street count of June 1998 (Dublin Simon, 2000). According to figures from the UK
apartment of the Environment, Transport and the Regions, the UK Rough Sleepers Count of June 1999
jwed that there were more rough sleepers in Dublin than in Oxford (52), Manchester (44), Birmingham
)), Nottingham (31) and Liverpool (30) *combined.* Furthermore, compared to the UK's Homeless Network
•eet Monitor Count of January 1999, the number of rough sleepers in central Dublin was more than two-
rds the number of rough sleepers in central London (302) (cited in Dublin Simon, 2000).

; well as the number of homeless people increasing in Ireland, research has also found that homeless people
; remaining homeless for longer. For instance, Focus Ireland found that in 1993 the average length of stay
households in emergency B&B accommodation in the Dublin City Council area was 16 nights (Moore,
94). However in 1999 this had increased to 81 nights (Houghton and Hickey, 2000).

[gar *et al.* (1999) proposed four reasons for the increased levels of homelessness in Europe. Demographic
anges, such as people living alone as single adults for longer periods, an increase in separation and divorce
d the extension of life expectancy means that the level of demand for housing units has grown rapidly,
condly, socio-economic changes, including economic globalisation, market liberalisation, industrial
structuring and technological advances have led to the decline in well-paid full-time jobs and increase in
lundancy and dependency on social welfare provision. Another consequence of globalisation is a loss of
rise of community, which may result in homelessness (Daly, 1996). Thirdly, there are increasing numbers of
ople dependent on social welfare payment, which is often below the average income. Finally, changes in the
using market, such as the privatisation of housing and the decline in the provision of social rented housing
s led to low-income groups becoming increasingly dependent on housing benefit payments.

.3 Characteristics of Homeless People

itherto, research on homelessness concentrated on the biographic causes of homelessness. Now it is agreed
at structural issues, such as poverty, unemployment and housing shortages cause homelessness (Homeless,
gency, 2001). While the underlying cause of homelessness is poverty, this is often combined with a personal
isis such as family breakdown or eviction (Homeless Agency, 2001).

le profile of homeless people has changed in Ireland. Harvey (1998) has alluded to the *feminisation* of the
tmeless population as there are increasing numbers of women becoming homeless. There are also greater
imbers of homeless families due to increasing levels of domestic violence, family breakdown and men being
irred from their family home (Homeless Agency, 2001). Therefore, homeless families are often considered
be victims of circumstance (Pleace *et al,* 1997). Lone parents with dependent children are at particular risk
'becoming homeless (Greve, 1997). They are often dependent on social security benefit, which makes them
llnerable in the housing market.

omeless people are a particularly vulnerable group. Indicators of vulnerability include mental health
oblems, alcohol and drug dependency, untreated physical health problems, previous experience of
stitutions and low levels of life skills (O'Leary, 1997).

esearch has shown that there is a high prevalence of psychiatric illness among the homeless although
evalence varies considerably depending on the research instrument used and the population studied (Cleary,
)98; McKeown, 1999). Mental illness is considered to be most common among people sleeping rough
Andersen *et al,* 1993). Furthermore, it is believed that often the mental health problems of street homeless
ients will not be diagnosed (O'Leary, 1997). After *Planning for the Future* (1984), psychiatric care shifted
om an institutional setting to a community-based setting. This has led to patients being discharged
•ematurely without much support and assistance to reintegrate. As well as psychiatric institutions,
jinstitutionalisation from prison and care is also cited as a reason for increasing numbers of homeless people.
he experience of institutions often leaves people without sufficient social/life skills to live independently as
Ley are 'not just unable to manage, but unable to visualise exactly what independent living involves'
)'Leary, 1997: 9).

Recent research studies would indicate homelessness among drug users is increasing (Cox and Lawless, ; Costello and Howley, 2000). For instance, Cox and Lawless (1999) found in a study carried out with pro drug users that 93% had experienced homelessness at some point in time and 63% reported being homel< the time of interview. British research has found that 6% of hostel residents are drug dependent, 22% of p< in nightshelters are; as are 13% of rough sleepers (OPCS, 1996).

As well as drug problems, alcohol problems are also common among homeless people. Many homeless pi are said to have a 'dual diagnosis', i.e. both a mental health and alcohol or drug problem (OPCS] O'Leary, 1997). For instance, among a group of residents in cold weather shelters in London, 38% c sample had a 'dual diagnosis' (O'Leary, 1997). Dual diagnosis can lead to loss of accommodation, behavi problems and an unwillingness to co-operate with services (O'Leary, 1997). Therefore, many of them te fall through the system without being treated by drug services or psychiatric services. Homeless people mental illnesses are more likely to use alcohol, because they use this as a method of self-medication as are likely not to be in contact with services (O'Leary, 1997).

2.4 Irish Social Policy and Homelessness

In 1824 the Vagrancy Act was passed, although it was not applied to Ireland until 1871. The Act consist 50 vagrancy offences including begging and prostitution.

The first significant piece of legislation in relation to homelessness in Ireland was the 1988 Housing Act. Act specified local authorities as the statutory agencies with responsibility for homeless people. It stipu that a local authority set aside a proportion of the dwellings becoming available for letting to parti categories of people, including homeless people (Curry, 1993). It stated that the provision, improver management and letting of local authority housing should be regularly reviewed and up-dated to ensur needs of categories of people, such as the homeless, are met. It also enabled the local authorities to i arrangements with voluntary organisations to provide accommodation for homeless people and to assess respond to the needs of homeless people. This piece of legislation was important as it illustrated for the time an acceptance by the State of both responsibility for homeless problems and for assessment of their n (Edgar, *et al,* 1999). However, take-up of the responsibilities by local authorities was poor (Edgar, *et al,* If O'Sullivan (1996) described the legislation as 'permissive' as it allowed local authorities to assist the horn but they were not obliged to house them. He also felt that this Act 'contributed little to meeting the nee< the homeless' (20) especially when one evaluation report, four years later, found that only 157 horn people had been housed by local authorities. This piece of legislation linked the problem of homelessne the wider structural issue of housing availability. However, the multi-dimensional issues relate homelessness were largely ignored.

Lennon (1998) had three concerns with the Act. Firstly, although local authorities were given responsil for providing accommodation for homeless persons it created uncertainty as to whether care, sup resettlement and outreach services were the responsibility of the local authorities or the Health Bo; Secondly, voluntary organisations argued that the definition of homelessness used in the Act was too nai as it did not include those people threatened with homelessness. Finally, under the 1988 Act, hou authorities have a duty to conduct regular assessments of homelessness in their areas. However, volui agencies have expressed concern about the methods used as they feel the assessments underestimate number of homeless. Furthermore, O'Sullivan (1996) argues that acceptance onto the housing li: conditioned by local practices and availability of social housing, rather than by an objective assessment o housing needs of applicants.

The 1990s saw a redirection in Irish housing policy with greater emphasis being placed on the activities o voluntary and co-operative housing organisations. In 1991 the Child Care Act stated that the Health Bo had the responsibility for accommodating children up to 18 years. This strengthened the responsibility accountability of health boards in respect to young homeless people. The Department of the Environ issued two key policy documents - *The Plan for Social Housing* (1991) and *Social Housing - The Way A,* (1995). These led to an expansion of the local authority housing programme and an increase in resource social housing. However, there was still a general failure among policy makers to make the connect

between homelessness and the wider world of social policy, poverty and social exclusion (Homeless Agency, 2001).

In 1996 the Dublin Homeless Initiative was set up as a result of the *Review of Service Provision for the Homeless in the Dublin Region* (1995). The Initiative operated under the joint direction of the Eastern Health Board and Dublin City Council and applied to Counties Dublin, Kildare and Wicklow with the aim of improving the co-ordination, planning and delivery of service provision for homeless people. The Homeless Initiative was cited as the main forum for dialogue and debate on key issues regarding homelessness by providers of services for homeless people (Lennon, 1998). Edgar *et al.* (1999) considered the establishment of the Homeless Initiative as an innovative response as it 'propose[d] the co-ordination of a comprehensive review of ways to improve delivery of services to homeless people in a large regional area. The emphasis is on planned development and delivery of services, which embraces flexibility amid consultation and co-ordination. This is an unprecedented development in the Irish context in relation to homelessness' (184).

Towards the end of the 1990s, it was evident that homelessness in Ireland proved to be persistent and resistant to the solutions offered by the Irish government. Although belatedly, the government launched *Homelessness - An Integrated Strategy* in May, 2000 which aimed at dealing with homelessness by bringing together the various statutory departments and voluntary agencies to provide a more coherent and integrated delivery of services to homeless persons. The new *Strategy* indicated that Irish policy, similar to other EU states (see Edgar *et al,* 1999), has shifted from viewing the nature and causes of homelessness in individual pathological explanations towards socio-structural explanations. It is a clear recognition of the multi-dimensional nature of the problems which homeless people present with, as it recognises the necessity to tackle deeper causes such as housing shortages and basic health care. Primarily it is a settlement strategy as it aims to facilitate the movement of homeless people through a continuum of care from emergency, temporary accommodation to permanent, stable and secure accommodation of appropriate standard and with appropriate support services. Issues of support, income and employment as well as accommodation are simultaneously addressed. The *Strategy* requires forums to be set up in each county in Ireland with local authorities and health boards contributing co-ordinated three-year action plans to provide more accommodation, settlement and outreach programmes to help homeless people back into independent living. It also targets at-risk groups such as those leaving prison or health related care. The new approach is based on the principle of continuum of care to ensure the needs of homeless people are met in an integrated way (Homeless Agency, 2001). As part of the *Strategy,* the Homeless Agency was established to lead the implementation of the Action Plan and to manage the delivery of services to people who are homeless in Dublin. According to Edgar *et al.* (1999) innovative policies related to homelessness include funding pilot programmes and creating new agencies. The new Irish *Strategy* has succeeded in both.

One anomaly with the *Strategy* is that homeless people were not consulted in the shaping of the content. This disempowers homeless people, as user involvement 'becomes a prerequisite for the development of capacities and potential for independent living' (Edgar *et al.,* 1999: 54). Edgar *et al.* (1999) believe that when service users are given power over decisions affecting their welfare there is a redistribution of power away from service and support providers. Edgar *et al.* (1999) would also question the accuracy of conceptualising homeless people's situations, as a 'continuum of care' needs. They argue that 'people who have a mental illness or have drug or alcohol problems have needs which may fluctuate from requiring very high levels of support to periods involving lower levels of dependency' (103). Therefore they would prefer a diversity of linked services which enables people to move up and down a 'ladder (or staircase) of care' (Edgar *et al,* 1999: 103). This means that policy not only offers appropriate responses through the integration of services, as is the case in Ireland, but also has the ability to respond flexibly to changes in the user's circumstances or needs.

2.5 Current Service Provision

Homeless services include hostels, food centres, advice and information services, outreach, settlement, medical, psychiatric and education services. The main statutory providers of services for homeless people in Dublin are the local authorities (the largest being Dublin City Council) and the health boards. The local

authorities provide funding (recoupable from the Department of the Environment and Local Government) to voluntary organisations for capital and running costs of housing, hostels and food services. Dublin City Council also funds half the costs of the Homeless Persons Unit (HPU) and fully funds the after hours service run by the HPU. The Department of Social, Community and Family Affairs finances B&B accommodation and provides income maintenance (supplementary welfare allowance), exceptional needs payments and income supplements towards health charges. However, the persistence of homelessness indicates that service provision is not meeting homeless people's needs. Lennon (1998) recommended that these services should be improved by clearly defining the role of statutory bodies, increasing resources and developing a co-ordinated and accessible service.

Service provision for the homeless in Ireland relies more on voluntary organisations than other European countries. The majority of voluntary agencies receive funding from at least one or more state agencies in addition to their own fund-raising activities. This has led to voluntary organisations forming a closer relationship with statutory agencies (O'Sullivan, 1998). Since the early 1990s, the state has increasingly moved away from the financing and provision of welfare services to merely their financing and regulation (O'Sullivan, 1998). It is believed that this trend will continue in the 2000s and the majority of welfare services will be provided by the voluntary sector or by semi-independent bodies (O'Sullivan, 1998).

According to Harvey (1998) there are significant gaps in the provision of services for the homeless in Ireland given the low level of voluntary sector development, and the underdevelopment of reintegrative, social and psychological services. Overall homeless services have been criticised for being inadequate and under-resourced (Lennon, 1998). Furthermore, although the services in Dublin are concentrated in they city centre, they continue to be fragmented and uncoordinated (Homeless Agency, 2001). Therefore, homeless people have to travel from one service to the next. Houghton and Hickey (2001) summarised literature on difficulties homeless people have in accessing services. These included financial costs, transportation and distance, lack of knowledge and waiting times. Lennon (1998) recommended that a 'One Stop Centre' was needed in central Dublin which would include information, advice and help on housing, accommodation, social welfare and health. She felt this would provide a co-ordinated response to homelessness as people who wanted information could be dealt with quickly while those with more complex needs could be allocated a key worker to assist them through a continuum of care. While this idea has still not materialised in Dublin, one-stop services have been successful in cities in Britain, such as Bristol (Pannell and Parry, 1999; Stern *et ah,* 2000).

2.5.1 Accommodation

One of the main objectives of current housing policy is to enable a prompt and adequate response to the accommodation needs of homeless people (Department of Environment, 1995). Accommodation referral services for homeless people are operated by local authorities and by health boards or, on their behalf, by voluntary bodies. Section 10 of the Housing Act 1988 conferred additional powers on local authorities to respond to homelessness by directly arranging and funding emergency accommodation and/or making contributions to voluntary bodies towards the running costs of accommodation provided by them. However, Houghton and Hickey, (2001) found that accommodation provision is not meeting the needs of the homeless, given the fact that there are high levels of accommodation moves experienced by this group.

Local authorities' traditional response to homelessness was to allocate tenancies in their housing stock to homeless persons who applied for local authority housing. However, Drudy and Punch (2001) attribute the current housing 'crisis' to the government's failure to develop a vibrant social housing sector. Hitherto, local authority housing was a source of affordable, secure accommodation. Now the output is completely inadequate (Drudy and Punch, 2001). For instance, although there were 43,000 families on the waiting list in 1998, only 2,800 houses were built by local authorities (Drudy and Punch, 2001). Therefore it is not surprising that the number of people on the housing waiting list has increased dramatically. The number of people on waiting lists almost doubled from 1996 to 2002. In 1996 there were *21,All* households on waiting lists and this increased to 48,413 by September 2002 (DOE, 2002). This increase is due to less social housing being built and also to the government selling social housing to sitting tenants. In 1996 to 1998, 8,079 houses were built by local authorities in Ireland although 6,429 were sold to local authority tenants over the same period

(Drudy and Punch, 2001). Drudy and Punch (2001) argue that this is;

> in effect the "commodification" of public housing, whereby housing produced for social ends has been privatised and becomes a commodity which may be used for profit-taking as opposed to its primary function of providing shelter (243).

Since 1984, voluntary agencies have moved away from the mere provision of hostel accommodation to providing social housing (O'Sullivan, 1998). Therefore, this shows how voluntary agencies have now become the key providers of long-term accommodation for the homeless (O'Sullivan, 1998).

The current shortage in local authority housing has left many people vulnerable to becoming homeless. Homeless people interviewed by Focus Ireland said that they would like to see a quicker City Council response in relation to housing (Houghton and Hickey, 2001). While the shortage of housing affects all homeless people, young homeless people and older single men face particular difficulties, as they are not generally eligible for local authority housing. Feminists would argue that patriarchal assumptions are embedded in housing production therefore reflecting the ideals of marriage, children and shared activities (Neale, 1997). Therefore, groups of people who do not conform to this pattern (e.g. gay and lesbian families, lone-parent families and single person households) are discriminated against (Neale, 1997). According to O'Sullivan (1996) the decrease in social housing and the increase in growth in the owner-occupier and private rented sector has led to a 'socially and economically constructed owner occupier dominant club of housing tenure' (83). In fact, Ireland has the highest proportion of owner occupation (80%) in the European Union (Drudy and Punch, 2001). Conversely, the number of houses being rented from local authorities in 1998 was 7.8% (Drudy and Punch, 2001).

Homeless people can avail of private rented accommodation as an alternative to local authority housing by using the SWA rent supplement paid by the health boards. However there is a lack of affordable rented accommodation in Dublin due to the mismatch between supply and demand. Therefore, much of the accommodation in the private sector, in which homeless people are placed, is in poor condition. Tenants in the private rented sector face many problems including rent uncertainty, illegal evictions, deposit retention, low quality, unfit dwellings in terms of fire and safety and escalating rents (Drudy and Punch, 2001).

As a result of the increases in rent in the private rented sector and a decrease in availability of rented accommodation there is increasing pressure being placed on emergency accommodation. There are 681 emergency beds in hostels and women's refuges in Dublin although it is estimated that fewer than half of these are available for emergency access as the rest are occupied on a long-term basis by residents. Most beds are for men only, with only 135 hostel and 20 refuge beds available for women, either on their own or with children (Homeless Agency, 2001). The majority of hostel accommodation is provided by voluntary agencies who are eligible for capital assistance. However, this does not cover maintenance and repair of property. The hostels in Dublin mainly cater for single people and offer single units or dormitory style accommodation. The Housing Department of Dublin City Council has funded the refurbishment of some hostels. Consequently, conditions in hostels vary with renovated hostels reaching quite a high standard in recent years while others remain in poor condition with large dormitories, limited amenities and little reference to health and safety standards. Provision of emergency accommodation in Dublin was criticised by homeless people because of a lack of hostels catering for men, women and children and drug users or alcoholics, a lack of blankets and a lack of self-catering units (Houghton and Hickey, 2001).

Local authorities, health boards and voluntary bodies use B&B accommodation when hostel accommodation is not available. Although B&B accommodation is intended to be used only as emergency or short-term accommodation there has been a substantial rise in the use of B&Bs in Dublin, and an increase in the length of time people spend there (Houghton and Hickey, 2000). However B&B accommodation is unsuitable for long-term use, particularly for families, as research has found that it is unstable, it is inappropriate in terms of privacy and social isolation, it impacts on the health of those staying there and it lacks appropriate support structures (Houghton and Hickey, 2000).

Homeless people trying to access accommodation can use the Eastern Regional Health Authority Freephone helpline. Almost three-quarters (71%) of rough sleepers used this service in 2000, although 65% were dissatisfied with the service. The main complaint was that there was no accommodation available when they rang it (Dublin Simon, 2000).

While accessing accommodation can be problematic for all homeless people, it is particularly difficult for certain groups such as young people, families, drug users and those with mental health problems. Young people have difficulty accessing emergency accommodation, as they are not a priority group for resettlement. Families find it difficult as there are no family hostels and they sometimes have to separate as a result. People with alcohol or drug related problems cannot access accommodation as many hostels operate on a 'no drink rule' or 'no drugs rule'. Policies differ among hostels due to the different client groups catered for and in part to the fact that hostels are managed by different organisations. Furthermore, specialised emergency accommodation for people who are physically or intellectually disabled is non existent (Lennon, 1998).

As a result of the housing crisis in Dublin, it is not surprising that there is an increasing number of homeless people. Daly (1993) has pointed out that:

> when housing supply is inadequate, either because of an absolute shortage or an insufficiency of a range of accommodation types, the risk of homelessness increases out of proportion to the prevalence of economic and social problems (5).

2.5.2 Day Services

Day centres are vital for homeless people as they provide a range of services from social support, warmth, shelter and emergency assistance through to specialist advice and support, healthcare, resettlement and help into training and employment (Cooper, 1997). For homeless people 'the most significant thing that a Day Centre offers is respite and sanctuary from the daily pressures of being homeless, lonely and vulnerable in a hostile society' (Cooper, 1997: 3). However, there are not many day centres in Dublin which means that many homeless people are obliged to spend the day outdoors and walking around the streets (Holohan, 1998).

2.5.3 Health Services

There has been much research in recent years examining reasons why homeless people have difficulty in accessing existing health and medical services. Harvey (1998) found that there is evidence that homeless people experience difficulty in using some health services, finding many services unsympathetic, inappropriate and ill-equipped to meet their needs. Holohan (1998) identified four barriers that prevented homeless people in Dublin accessing health services. These were financial barriers, unhelpful staff members, fear and intimidation and a perception among homeless people of preferential treatment being given to refugees and asylum seekers.

Homeless people have reported difficulties registering with a GP and as a result access to GP services is poor (Pleace and Quilgars, 1996). Furthermore, Anderson *et al.* (1993) found that even though they were registered with a doctor many single homeless people were not receiving treatment for their health problems. Winn (1994) found that GPs in London were particularly inaccessible to homeless people as they 'have highly restricted opening hours, unwelcoming reception areas, a lack of interpreting services, inaccessible locations and little information available about them' (3).

As a result of these barriers of access to primary health care services, homeless people are more likely to use accident and emergency services (A&E) as an entry point into the health service. In their analysis of data collected from different A&E departments from seven different hospitals, Scheuer *et al.* (1991) found that homeless people were two or three times more likely to make unplanned use of hospital services. However, Pleace and Quilgars (1996) found that homeless people were sometimes treated with prejudice in A&E.

One indicator of the inadequacies in the provision of services for homeless people is the level of mental illness among them. According to Harvey (1998) services which address the mental health needs of the homeless are less well developed in Ireland than in most other European countries. McKeown (1999) cites several reasons for this. Primarily access to psychiatric services in Ireland is based on where people are from. Therefore, as many homeless people gravitate to Dublin, many of them cannot access psychiatric services. Secondly many people who are homeless do not present themselves for services. Thirdly, and most importantly in McKeown's (1999) view, there are few services available and those that are available are poor. According to British research, street homeless with a dual diagnosis are often disowned by both alcohol services and psychiatric units. Furthermore these services are often fragmented and make if difficult for clients to get treatment from

both (O'Leary, 1997). Therefore, many of them buy required medication illegally on the streets (Flemen, 1997).

2.5.4 Specialist Programmes

Priority and immediate access to drug and alcohol treatment centres is extremely difficult for homeless people (Lennon, 1998). Alcohol treatment services are not necessarily appropriate to the needs of homeless street drinkers and in any case are very difficult for them to access (Costello and Howley, 1999). Furthermore, homeless services' personnel are often not qualified to deal adequately with drug users and access to health board workers and psychological services is often problematic (Lennon, 1998). Homeless people dependent on heroin often find it difficult to access methadone through a GP or treatment clinic (Flemen, 1997).

2.6 Information and Advice Services

Information and Advice Services are particularly important for homeless people, as lack of knowledge is often cited as a barrier to accessing different services, such as health, education and social services. Furthermore, advice services for homeless people may bring about change in an individual's life situation (Edgar *et ah,* 1999). This is consistent with Giddens' (1984) theory of 'structuration'. While homeless people seem to have little power and control in society, they do have some power to change their situation as personal circumstances are not predetermined and social structures operate at different levels (Neale, 1997). Homeless people often have little or no knowledge of available or appropriate services and they have found it difficult to access information on services relevant to them (Homeless Initiative, 2000; Houghton and Hickey, 2001). Homeless people in Dublin have reported that there is a lack of advice centres and legal aid (Houghton and Hickey, 2001). Following discussions with service providers, Lennon (1998) cited several gaps in information provided to homeless people. Firstly she found that information was not available in a user-friendly language and format. Secondly, up-to-date information on the range of services and benefits for homeless people was not freely available. Thirdly, service providers reported that there was a dearth of information on medical entitlements and facilities, crèches, showers and laundry facilities, housing advice, welfare entitlements, rent allowances and counselling services.

Methodology

This chapter outlines the research methodology, which was employed to achieve the objectives of the stud The aim of the evaluation was to encourage service user participation and the importance of this method outlined. Thereafter, the chapter delineates the research instruments that were used and describes how the da were analysed.

3.1 Participatory Research

Service users were involved at several stages during the research process. This meant that they were able i give their views and opinions on the delivery of the Information and Advice Service. The service users wei also met at the end of the research process to discuss the findings and recommendations. Services can only r. responsive to users' needs if the organisation has feedback from service users. According to Edgar *et a* (1999), it is important to involve service users in the types of services offered, and the conditions under whic they are provided, or else homeless people's lives become 'colonised' in the sense that, as a condition c service provision they are 'forced' into conformity and compliance within the norms of the wider societ Furthermore, it also creates a sense of ownership within the centre, which may lead to service users feelin more able to take responsibility for their own lives and become less dependent on the service (Edgar *et at* 1999).

Interviews were also carried out with staff, as interests and expectations of the clients and staff must b simultaneously served. This is in keeping with the principles of the Homeless Agency (2001), in that the skill: experience and expertise of people providing services to people who are homeless are valued and inform th planning and development of services. It is also hoped that staff working within the context of constrainin and permissive structures, inherited from the past, can 'make strategic, organisational and operation* decisions and choices about the delivery of services' (Edgar *et al,* 1999: 53).

3.2 Process Evaluation

It was decided that process evaluation was the best method to assess the Fáiltiú Information and Advic Service. This involves examining what the activity involves and the manner in which it is implemented, rathe than the outcomes which result. Consequently, identifying, describing and analysing the process are the cor elements in assessing the service's effectiveness (Murray *et al,* 1994). The aim of process evaluation is t provide information for programme improvement, modification and management (Robson, 1998). Therefore process evaluation involves extensive contact and consultation with service users and staff (Murray *et al.* 1994).

3.3 Sample

A probability sample was not feasible for this study, as there was no available sampling frame. Consequently the only sampling method possible was convenience sampling. This involves 'choosing the nearest and raos convenient persons to act as respondents. The process is continued until the required sample size has beer

reached' (Robson, 1993: 141). Convenience sampling is often criticised as it is biased and can influence who gets sampled. Therefore to reduce sampling bias, interviews were conducted at different times during the day.

3.4 Data Collection

A combination of qualitative and quantitative methodologies was used in this study as evaluations benefit from the use of multiple methods (Robson, 1998).

3.4.1 Focus Groups

Two focus groups were carried out at the beginning of the data collection process with staff members and service users. Focus groups were used as they 'are ideal for exploring people's experiences, opinion, wishes and concerns' (Kitzinger and Barbour, 1999: 5). Carrying out focus groups before the design of the questionnaire gave the service users and staff a voice in the design and implementation of the research. During the focus groups, the researcher assisted participants to reflect on the Information and Advice Service, raise questions about the process, as well as examining the impact of the activity.

3.4.2 Screening Questionnaire

A screening questionnaire was designed to identify the percentage of clients using the Information and Advice Service who were then eligible to continue with the longer questionnaire. This survey also sought to elicit baseline data on the clients attending the Fáiltiú Resource Centre.

3.4.3 Evaluation Questionnaire

The questionnaire was constructed based on the themes that evolved in the focus groups. The evaluation also used performance indicators recommended in the handbook *Putting People First* (Courtney, 1999) which is an overall quality improvement programme for homeless services. The data were collected using an interviewer-administered questionnaire to ensure that service users with any literacy problems were not excluded. The questionnaire was arranged into the following content subsections, using some questions already standardised in research literature.

a) Evaluation of the Fáiltiú Information and Advice Service

Questions looked at clients' use of the Information and Advice Service and asked about difficulties in requesting information. Thereafter, clients were asked about their views on a key worker system. Questions were also asked on the availability of leaflets and their usefulness. The respondents' attitude towards the information provided and the attitude of the staff were measured using a five-point Likert scale ranging from (1) very poor to (5) very good. Open-ended questions were used to allow clients to give their views on how the current services could be improved.

b) Demographic Information

Demographic questions were asked on the respondents' age, nationality, marital status, children, educational attainment, employment status and criminal history. These questions were asked to give further insights into the characteristics and needs of the client group.

c) Detail regarding homelessness

The following section elicited information on the circumstances surrounding and duration of homelessness. These questions were asked as it is generally agreed that in developing effective, innovative services, it is important to understand the processes by which homelessness may occur and to understand the nature of these processes at an individual as well as a structural level.

d) Lifestyle risk factors

The fourth section elicited information on lifestyle and behavioural risk factors concerning alcohol consumption and the use of illicit drugs. Questions on alcohol related risk factors were replicated from Feeney *et al.'s* (2000) study of homelessness and health. Questions on illicit drug use were taken from a research

instrument designed by Merchants Quay Ireland's drugs service. This enabled comparisons to be made between client groups accessing different services within the organisation.

e) Heath Status

The next section elicited information on the respondents' physical and mental health and their use of health services. The question on general health was self-reported while an objective evaluation was carried out of respondents' psychiatric health status. A 22-item physical checklist was used to record health complaints, replicated from the Irish study on homelessness and health by Feeney *et al.* (2000). Finally the participants' contact with health services was measured covering medical card ownership and frequency of attendance at GP, dentist, outpatient clinics and addiction services in the last 3 months. This question was also replicated from Feeney *et al.* 's study (2000) in order to compare data and identify common and unique features of the Dublin homeless population.

3.5 Data Analysis

Participants' permission was given to tape the focus groups and these were subsequently transcribed. The qualitative data were then coded into different themes and ideas and analysed accordingly.

The results from the questionnaire were entered directly into SPSS 10 for Windows. All percentages given in the report are based on valid responses adjusted for missing data. Categorical variables were analysed using chi-squares and 95% confidence interval (CI). The continuous data were highly skewed, so they were analysed using the Mann Whitney U Statistic. Open-ended questions were coded into categories that were both exhaustive and mutually exclusive. The qualitative data were converted therefore into numerical codes in order to perform quantitative analysis. However, open responses were also used as verbatim comments within the report to illustrate points rather than reducing them just to numerically coded categories.

3.6 Ethical Considerations

Responses to the questionnaire and focus groups were anonymous and confidential and this was stressed to all potential interviewees.

Screening Data

As discussed in Chapter Three, a screening questionnaire was designed to be administered to service users attending the Fáiltiú Resource Centre. The main purpose of the questionnaire was to identify the percentage of clients using the Fáiltiú Information and Advice Service who were then eligible to continue with the longer questionnaire. Furthermore, the screening questionnaire provided baseline data on clients attending the Fáiltiú Resource Centre.

During the weeks of 12th February to 21st March 2001, clients who entered Fáiltiú Resource Centre were asked whether they would complete the screening questionnaire. During this period a total of 115 clients agreed to complete the questionnaire. In this chapter the data collected from the 115 questionnaires are presented.

4.1 Demographic Profile

Figure 4.1 illustrates that of the 115 clients who participated in the completion of the screening questionnaire 82% (n = 94) were male and 18% (n = 21) were female.

FIIGURE 4.1 GENDER OF SERVICE USERS

Female
18%

Male
82%
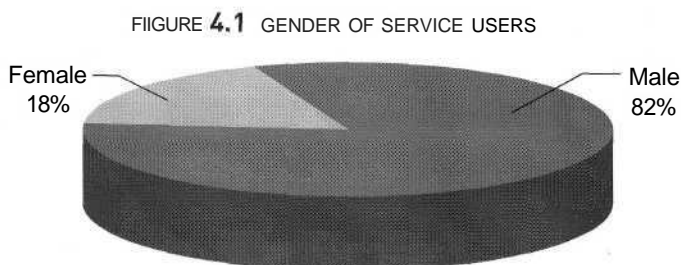
This gender profile is similar to other studies on homeless populations in Ireland (Holohan, 1998). This indicates that similar to other countries (Smith, 1999), there are increasing numbers of women among the Irish homeless population.

The mean age of clients presenting at Fáiltiú Resource Centre was 32.6 years (median = 30 years; range 18 - 78 years). The vast majority of respondents were younger than 45 years (87%, n = 100) and only 13% (n=15) were over 45. The age distribution in this study was younger than that found in other studies (Holohan, 1998; Feeney *et al.* 2000). This supports international literature which suggests that the homeless population is getting younger (Daly, 1993).

Female clients were significantly younger than their male counterparts (z = -2.39, p < 0.05). The mean age of female clients was 30.1 years (median = 27, range = 18-78 years) while the mean age for male clients was 33.2 years (median = 32 years, range = 19-66 years). Similarly, female clients in the Merchants Quay Contact Centre are significantly younger than male clients (Cox and Lawless, 2000).

4.2 Current Accommodation

All respondents were asked where they were living at the time of interview. The following table shows the types of accommodation used by the clients.

TABLE 4.1   LIVING ARRANGEMENTS OF SERVICE USERS

Accommodation	Number	Percentage (%)
Emergency hostel	41	36
Sleeping rough	16	14
B&B	i5	13 -
Local Authority flat/house	10	9
Parent's home	8	7
Long-term hostel	8	7
Squat	6	5
Private rented house/flat/bedsit	3	3
Relatives	2	2
Friends	1	1
Other	4	3

Missing values: 1

Table 4.1 shows that over a third of the respondents (n = 41, 36%) were staying in emergency hostels while 14% (n = 16) were sleeping rough. The large number staying in emergency accommodation is probably due to the fact the majority of hostels for homeless people in Dublin are located in the city centre, within close proximity of the Fáiltiú Resource Centre. The substantial number of rough sleepers attending Fáiltiú reflects an increase in the number of rough sleepers within the homeless population in general (Carlen, 1996). Over one-tenth of the respondents (13%, n = 15) were staying in B&Bs while ten respondents (9%) were living in local authority housing. Male respondents were more likely to be living in a hostel (n = 45, 48%) whereas female clients were more likely to be staying in B&B accommodation (n = 7, 33%). This is not surprising, as the majority of those using B&B accommodation in Dublin are women with children (Houghton and Hickey, 2000; Smith *et al,* 2001).

Analysis revealed that there were age differences across accommodation types. Table 4.2 shows that those living in local authority or private rented accommodation were proportionately older than those living in a squat or with relatives or friends.

TABLE 4.2 AGE BREAKDOWN BY ACCOMMODATION TYPE

Accommodation type	N	Mean age	Median age	SD	Range
Private rented	3	52	55	10.8	40-61
Local authority	10	40	36	9.7	28-57
Long-term hostel	8	37.5	38	15.4	18-66
Emergency hostel	41	31	30	7.9	19-58
Parent's home	8	29.6	28.5	8	21-44
B&B	15	28.9	27	8.6	20-51
Sleeping rough	16	28	21	8.4	21-49
Squat	6	27.5	25.5	9.4	18-42
Friends	1	25	25		25-25
Relatives	2	21.5	21.5	0.7	21-22
Other	4	53	53	24.7	28-78

Missing values: 1

bur out of five of the respondents reported being homeless (80%, n = 92)[2]. Those who were not homeless 20%, n = 23) were living in local authority or private rented accommodation, living with their parents, in their wn house or in transitional housing. Those who were not considered homeless were significantly older than lose who were homeless (z = -3.41, p < 0.005). Those who were homeless had a mean age of 30.5 years nedian = 28.5, range = 18 - 66) while those who were not homeless had a mean age of 41 years (median = 5 years, range = 21 - 78).

espondents were asked how long they had been living in their present accommodation. The results are lown in Table 4.3.

TABLE 4.3 LENGTH OF TIME IN CURRENT ACCOMMODATION

Length of time	Number	Percentage (%)	Cumulative Percentage (%)
Less than one week	15	13	13
1 - 4- weeks	29	26	39
1 - 5 months	20	18	57
6 -11 months	10		65
1 - 4 years	20	18	83
5 years or more	19	17	100

Missing values: 2

able 4.3 illustrates that only 17% of clients (n = 19) had been living in their current accommodation for more lan 5 years while a total of 13% (n = 15) had been living in their accommodation for less than one week, lmost two thirds (65%) had been living in their accommodation for less than one year.

i order to attempt to estimate the extent to which clients are 'at risk' of becoming homeless all respondents ere asked whether they regarded their current accommodation as temporary or permanent. Over four-fifths f the respondents (87%, n = 100) reported currently living in temporary accommodation. This figure is ightly larger (yet includes) those who reported being homeless. An examination of those clients who were *lused* revealed that many felt insecure in their current accommodation. For example, all of those living in ivate rented regarded their accommodation as temporary, 20% of those in local authority housing also ;garded their accommodation as temporary as did 38% living in their parents' home. Those living in mporary accommodation were significantly younger than those in permanent accommodation (z = -2.06, p 0.05). The mean age of those living in temporary accommodation was 31 years (median = 29 years, range 18 - 66) compared to a mean age of 41 years among those who were living in permanent accommodation nedian = 35 years, range = 21-78 years).

.3 Attendance at Fáiltiú Resource Centre

he respondents reported attending the Fáiltiú Resource Centre for a mean of almost 2 years (100 weeks), owever, 50% (n = 54) of the respondents had been attending Fáiltiú for a year or less. Twenty-five spondents (23%) reported attending Fáiltiú for 5 years (i.e. since it opened).

he clients reported attending the Fáiltiú Resource Centre on average 4 days a week although 43% (n = 48) ported attending every day.

igure 4.2 illustrates the reasons why people chose to frequent the Fáiltiú Resource Centre. Forty-nine ;spondents (43%) reported that they use the Fáiltiú Resource Centre for food. More than four in ten of the ients (41%) use the Fáiltiú Resource Centre for somewhere to go as there was *'nothing else to do', 'it gets*

For the purpose of this research, homeless clients are defined as those who reported living in a hostel, a B&B, a squat, staying with friends or sleeping rough.

Pieces of the Jigsaw

you out of the bad weather' and *'it passes the time while waiting on a hostel to open'.* Forty-five of the respondents (40%) use the Fáiltiú Resource Centre 'to talk to someone' (either a staff member or a friend). Importantly for this study, only three out often of the respondents (30%, n = 34) reported they came to Fáiltiú Resource Centre for advice and information. A quarter of the respondents use the Fáiltiú Resource Centre as a drop-in centre (n = 29, 25%) while over one-fifth (22%, n = 25) reported using the washing facilities and having a cup of tea (20%, n = 23). Less than a fifth of the respondents reported using the Fáiltiú Resource Centre for the telephone, referrals, settlement and counselling.

**FIGURE 4.2 REASONS FOR ATTENDING FÁILTIÚ RESOURCE CENTRE**
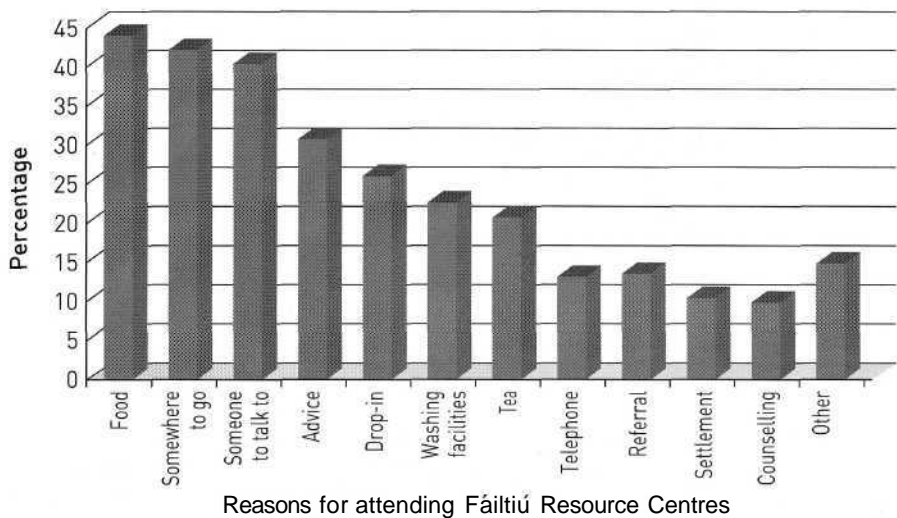
Missing values: 1

Respondents were asked to describe the Fáiltiú Resource Centre in their own words. The vast majority (95%, n = 104) described the Centre in positive terms while only 5 respondents (5%) described it in negative terms. The following table illustrates the important role the Centre plays in the lives of its clients.

TABLE *UM* POSITIVE DESCRIPTIONS OF FÁILTIÚ RESOURCE CENTRE

It's a real benefit to the community. It's good for people with any kinds of problems. It's good that it's here. (Male client> 23 years)

It gives out helpful information. Only for this programme I would be in the ground (Male client, 44 years)

It's very good. It's a great place and good for gettin' help. They 'll get you somewhere to stay. (Female client, 35 years)

It's very handy for anybody that's on the street, the way you can use the wash facilities and access the phones and you 're ensured a decent meal every day. (Male client, 27 years)

/ like this place cos you can meet people and the workers listen and help you the best they can. (Male client, 34 years)

It makes you feel at home. Everyone gives each other advice. It's like one big family. If we hadn 't got this we 'd have nowhere to go. (Female client, 29 years)

The comments made by the respondents were placed into themes. These are displayed in the following graph.

FIGURE 4.3 CLIENTS' PERCEPTIONS OF FÁILTIÚ RESOURCE CENTRE

Clients' perceptions of Fáiltiú
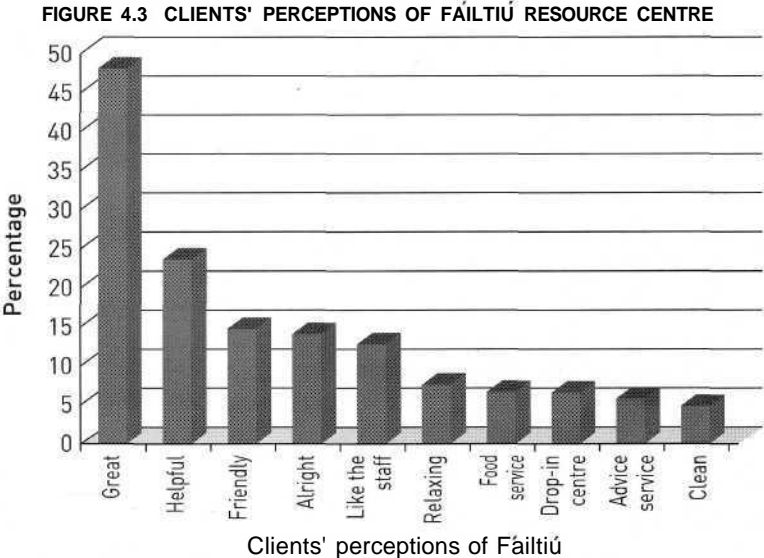
Missing values: 6

The above graph illustrated that when asked to describe the Fáiltiú Resource Centre a substantial number (n=41, 47%) reported that it was *good, great* or *excellent.* Over a fifth of the respondents (21%, n = 23) described the Centre as helpful, while a further 15 (14%) thought it was friendly. Fourteen of the respondents described the Centre as *all right* or *grand* while 13 respondents associated the Centre with the staff who were described as friendly, nice or helpful. Less than 10 people respectively described the Fáiltiú Resource Centre as a Food or Drop-in Centre (n = 7, 6%), or an Advice Service (n = 5, 5%).

In order to ascertain whether a client had used the Information and Advice Service they were asked whether they had ever approached a worker in Fáiltiú for advice or information or if they ever asked for help accessing other services. The results found that over two-thirds of those who attend the Fáiltiú Resource Centre use the Information and Advice Service (n = 78, 68%). It transpired in the focus group that those who did not access the Information and Advice Service were unaware that it existed.

> INTERVIEWER: DO you think that information and advice is an important part of the service offered by Fáiltiú?
>
> *R2 I didn 't know anything about it. It's a service that we're just not made aware of.*
>
> INTERVIEWER: SO you've never asked anybody any advice on accommodation, social welfare or health issues?
>
> *R2 No, I've been there over 18 months and I've never used it for anything other than food. Nobody's come up to me and told me anything about it. You 're talkin' about a part that I didn't know even existed.*
>
> (Male client, 30 years)

The majority of those using the Information and Advice Service use it for information on social welfare benefits, accommodation, health issues or referrals (n = 72, 64%) while less than a half used the service to access other services (n = 50, 44%). Those younger than 45 years were significantly more likely to approach workers in Fáiltiú for advice or information and to ask for advice accessing other services than those older than 45 years (df = 1, p < 0.05).

4.4 Discussion

The screening questionnaire provided valuable baseline information on the client group attending Fáiltiú Resource Centre.

Demographic Profile: The results showed that the demographic composition of the clients using the Fáiltiú Resource Centre has changed in that there are more young people and women accessing the services.

Current Accommodation: Over a third (36%) of the service users reported staying in emergency hostels. This type of accommodation can generate problems for individuals such as health, work and other personal problems (Neale, 1997). A substantial number of the service users were also sleeping rough (14%). Information and Advice Services are particularly important for rough sleepers as other studies have found that they are too alienated and their behaviour too chaotic for them to cope simultaneously with multiple services from several agencies (Lennon, 1998). The vast majority of service users were living in insecure accommodation as 87% reported that their accommodation was temporary. A fifth of the sample were not homeless. This would indicate that a proportion of those who attended the Tea Rooms run by the Franciscans in the past, are frequenting Fáiltiú. In 1992, 48% of those attending the Tea Rooms were either living in local authority housing or private rented accommodation. Furthermore, it is not surprising for ex-homeless people to continue using homeless services (O'Leary, 1997).

Attendance at Fáiltiú Resource Centre: A substantial number of service users at the Fáiltiú Resource Centre were regular attendees, with 43% attending every day. Over a fifth of the respondents (23%) reported attending the Fáiltiú Resource Centre for 5 years (i.e. since it opened). This would indicate that this group may be trapped in a cycle of homelessness and therefore need more help in obtaining independent living. The Centre plays an important role in the daily lives of the clients as 43% use it for food, 41% use it for somewhere to go and 40% go to Fáiltiú 'to talk to someone' (either a staff member or a friend). It is possible to conclude that the Fáiltiú Resource Centre effectively meets the needs of its service users, as the vast majority were very positive about the service provided there.

The results showed that the Information and Advice Service is important and necessary as more than two-thirds of the service users (68%) reported using this service. However, some of those attending the Fáiltiú Resource Centre were unaware that the Information and Advice Service existed. Lack of access to information reinforces the marginalisation and exclusion of homeless people (Narayan, *et al,* 2000). Significantly more young people than old people access the Information and Advice Service. Warnes and Crane (2000) found that in homeless services, older people's presence is often overshadowed by those of young users, who tend to be more demanding.

5

Profile of Service Users

This chapter presents an analysis of the demographic characteristics of the clients who use the Fáiltiú Information and Advice Centre. As outlined in Chapter Three, in order for individuals to be eligible to participate in the survey they had to have used the Information and Advice Service. The screening questionnaire identified 78 clients who use this Service. A total of 40 clients agreed to complete the evaluation of the Information and Advice Service, which resulted in a response rate of 51%. The data herein provide comprehensive information on the clients' background, homeless status, alcohol use, drug use, physical health, psychological well being and use of health services.

5.1 Demographic Profile

For the most part, participants were Irish (n = 37, 93%), one of whom was an Irish traveller. There were also 2 Northern Irish clients and one English client. This is consistent with other studies carried out among Irish homeless populations (Holohan, 1998; Feeney et al, 2000).

The majority of respondents identified themselves as single (n = 30, 75%). Over one fifth of the respondents were separated (n = 9, 23%) while only 1 respondent reported being married. Male respondents were more likely to be married or separated compared to female respondents.

More than two-thirds (n = 27, 68%) of the respondents had children. None of the respondents who had children were married. Among those who had children, two-thirds (n = 18, 67%) were single, while one-third (n = 9, 33%) were separated. Although not significant, female clients were more likely to have children than male clients. Among the female respondents 78% (n = 7) had children compared to 65% (n = 20) of male clients. Family sizes ranged from 1 to 6 children (mean = 3; median = 2; mode = 2). Of those who had children, 88% (n = 24) had children in the dependent category (under 18 years of age), while 22% (n = 6) had children over 18 years of age[5]. There were a total number of 61 children in the dependent category, whereas there were 12 children over the age of 18 years.

The mean age at which respondents had left school was 14.5 years (mode =15 years; median = 14.5 years). The youngest school leaving age reported was 11 years (n = 3, 8%) while one respondent stayed in full-time education until he was 22 years. Half the respondents (n = 20, 50%) were early school leavers (i.e. had left school before they were 15 years). This is two and a half times the national average of 20% (CSO, Census 1996) Furthermore, as the following table highlights, over half (n = 21, 53%) left school with no formal qualifications.

Table 5.1 shows that a large number of the respondents (n = 18, 45%) had no qualifications and 8% (n = 3) reported that the highest level of education they had reached was primary level. This is comparable to McCarthy's (1988) study carried out in the Simon Community in Galway where she found 45% had no educational qualifications and Feeney et al's (2000) study who found that 55% of their homeless sample had no education beyond primary school. Similar results (46%) were found in a national study of homeless people

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[5] The Child Care Act, 1991 defined a dependent child up to the age of 18 years (O'Sullivan, 1996).

Pieces of the Jigsaw

in Britain (Anderson *et ah,* 1993). Over a third of the respondents in this sample (n = 14, 34%) had obtained Inter Certificate level, while a further 8% (n = 3) had reached Leaving Certificate level. Two other respondents had gained qualifications in bricklaying and horticulture.

TABLE 5.1   QUALIFICATIONS OF SERVICE USERS

| Qualifications	Number (N)	Valid Percentage (%)	Cumulative Percentage (%)
None	18	45	45
No education beyond primary school	3	8	53
Intermediate Certificate	14	34	87
Leaving Certificate	3	8	95
Other	2	5	100
Total	**40**	**100**	**100**

A quarter of those interviewed were in employment (n = 10, 25%), while the majority were unemployed (n = 30, 75%). There were proportionately more male clients in employment (29%, n = 9) than female clients (11%, n = 1). Furthermore, those that were in employment were slightly younger (27.6 years) than those who were not (31.9 years). The following graph displays the employment status of respondents.

FIGURE 5.1 EMPLOYMENT STATUS OF SERVICE USERS

Unemployed 75%   Employed 25%
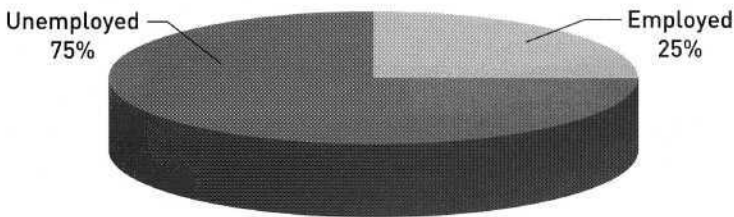
More than 6 out of 10 of the clients (n = 28, 65%) reported that they had been in prison at some point in time. Analysis revealed that male clients were much more likely to have spent time in prison compared to female clients. Over three-quarters (n = 24, 77%) of male clients had spent time in prison compared to only 22% (n = 2) of female clients. Figure 5.2 shows that of those clients who reported spending time in prison, 92% (n = 24) were male and 8% (n = 2) were female.

FIGURE 5.2 IMPRISONMENT BY GENDER


Male 92%   Female 8%
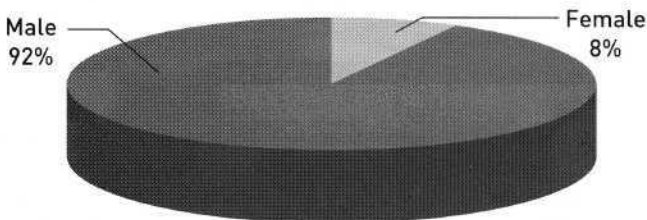
These figures reflect those of the Irish prison population, which is predominately male. Clients were also asked about their current legal status. Three clients reported that they were on suspended sentence, two were on probation, one was on temporary release and one claimed he was 'on the run'.

.2 Experiences of Homelessness

>r a third of the clients (n = 12, 33%) this was their first experience of homelessness. This is illustrated in 2 following figure.

FIGURE 5.3 EXPERIENCES OF HOMELESSNESS

Previously homeless 67%

First time homeless 33%
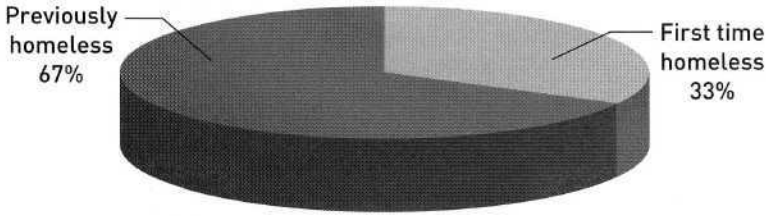
Missing values: 4

ie above figure illustrates that the majority of clients (n = 24, 67%) had already experienced homelessness. though not significant, male clients (n = 20, 71%) were more likely to have previous experience of imelessness than female clients (n = 4, 50%)

ie mean age that respondents first became homeless was 20 years (median =19 years, mode =16 years). Dwever further analysis revealed that 42% of the sample became homeless when they were 16 years old or lunger. The youngest age reported was 7 years while the oldest age was 39 years. Although,not significant, ale respondents tended to become homeless at a younger age than female respondents (19.8 years vs. 22.6 ars).

ie respondents were asked to identify how many times they had been homeless. Five respondents were table to give an exact figure but reported that they had been homeless *'on and off* for years. The responses the remaining clients are displayed in the following graph.

FIGURE 5.4 NUMBER OF TIMES HOMELESS
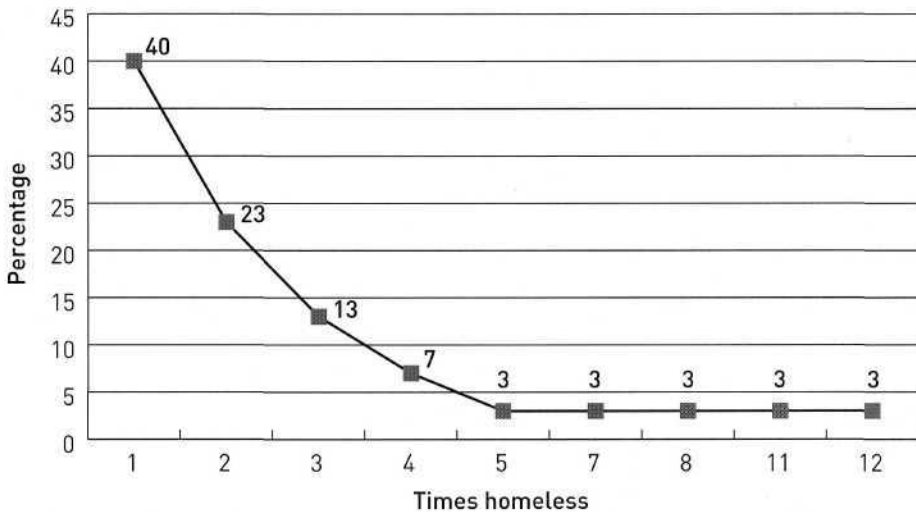
Missing values: 10

Pieces of the Jigsaw

Figure 5.4 shows that for 40% (n = 12) this was their first experience of homelessness. Almost a quarter of the clients have been homeless twice (n = 7, 23%) while 13% (n = 4) reported 3 episodes of homelessness. Almost a quarter of the sample (n = 7, 24%) reported in excess of 3 episodes of homelessness. Although not significant, male respondents have been homeless on average twice as many times as female respondents (3.4 times vs. 1.6 times).

The respondents were asked the longest period of homelessness they have experienced. The mean length of time homeless was 2.88 years (range 8 weeks to 15 years). The mean however is slightly skewed due to one of the respondents reporting being homeless for 15 years. The mode value is 2 years and median value is 2.25 years. Figure 5.5 graphically illustrates the results.

FIGURE 5.5 LONGEST PERIOD HOMELESS
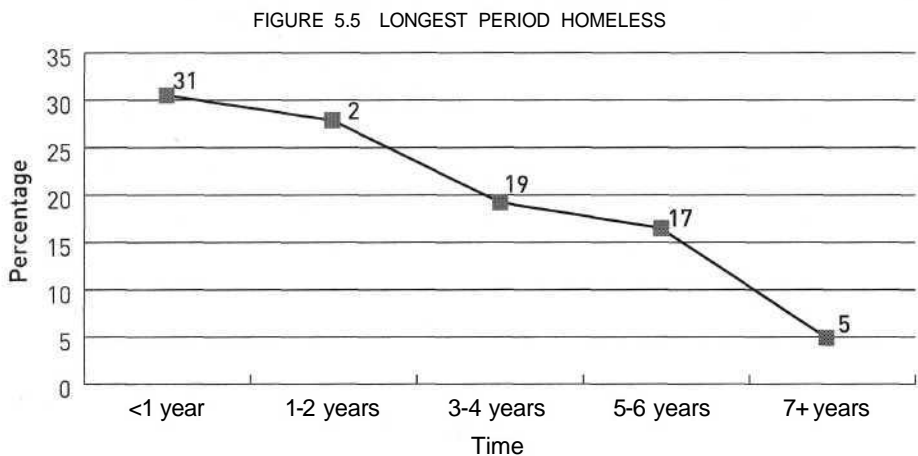
Missing values: 4

The above graph illustrates that almost a third of the respondents (n = 11, 31%) reported that their longest period of homelessness was less than one year. A further 28% (n = 10) reported that their longest time out of home was 1-2 years. Six percent of the sample (n = 2) reported that their longest period of homelessness was in excess of 7 years.

Respondents were asked to identify their primary cause of homelessness as well as identifying any number of secondary causes. This allowed the individuals to identify the most significant reason as well as identifying other causes. The inclusion of secondary reasons was to acknowledge that there is a multiplicity of reasons why a person can become homeless. These factors interact with one another, although one determinant may often impact more forcibly than others.

The most frequently reported life event that preceded homelessness was family conflict, accounting for over a third of respondents (n = 14, 39%). The second most cited reason for homelessness was drug problems (n =8, 22%) followed by alcohol related problems (n = 3, 8%). High levels of drug and alcohol problems indicate that the needs of homeless people are greater than just accommodation. Less than one in ten (n = 3, 8%) mentioned relationship problems. Overcrowded accommodation was mentioned by 2 respondents (6%) while other respondents mentioned domestic violence, eviction from private rented accommodation and rent increases.

Male respondents were more likely to have had relationship problems, alcohol problems or accommodation problems whereas female respondents were more likely to have experienced domestic violence. In Smith *et al.'s* (2001) study of one hundred homeless women in Dublin, domestic violence was the second most cited reason for homelessness.

The importance of drug related problems is reinforced by an analysis of the secondary reasons for homelessness. More than a quarter of the clients (n = 10, 28%) cited drug related problems as a secondary

reason for their homelessness. The second factor cited by respondents was family conflict (n =5, 14%). Other secondary reasons mentioned were structural (evicted from private rented accommodation, 8%, released from prison, 8%, unfit accommodation, 6%, overcrowded accommodation, 6%, returned to Ireland, 6%, left residential care, 3%, financial reasons, 3%, rent increases, 3%, evicted under anti-social legislation), and biographic (relationship problems, 6%, alcohol related problems, 6%, and domestic violence, 3%).

FIGURE 5.6 PRIMARY REASONS GIVEN FOR HOMELESSNESS
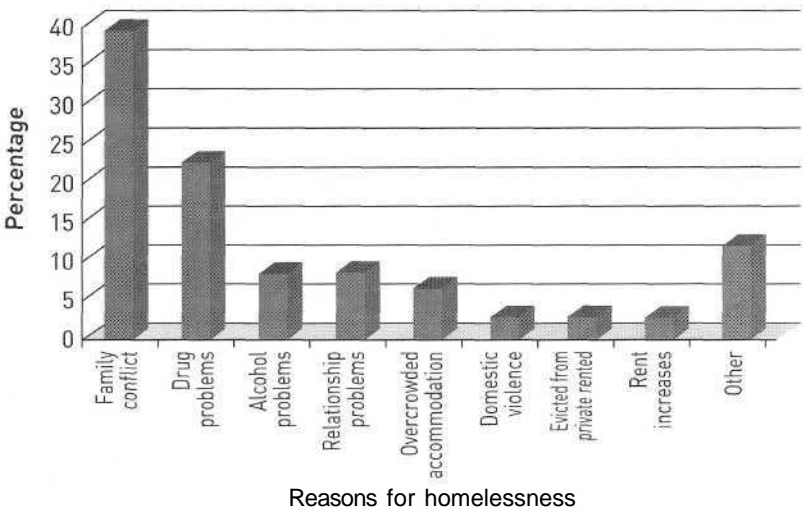
5.3 Alcohol Consumption

When asked how long ago they had consumed alcohol, 53% (n = 20) of the respondents replied in the last week. More than a tenth of the respondents (n = 5, 13%) last drank alcohol more than 12 months ago while 3 respondents (8%) have never had alcohol beyond sips or tastes. Overall 61% (n =23) were regular drinkers.[6] This is much lower than the 81 % reported in Feeney *et al's* study (1999) and the 72% in the general population (Friel *et al.,* 1999). Those living in long-term hostels and B&Bs were more likely to be regular drinkers. Furthermore, the following graph shows that a much higher proportion of female respondents were regular drinkers (88%) compared to male respondents (53%).

FIGURE 5.7 REGULARITY OF ALCOHOL **USE** BY **GENDER**

Missing values: 2

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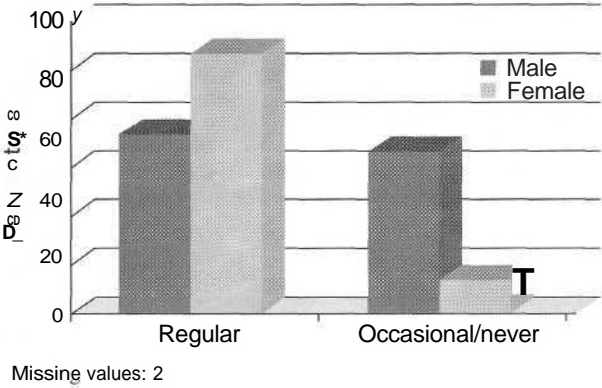
[6] Friel *et al.* (1999) define regular drinkers as those who consumed alcohol in the previous month.

Half of the sample (n = 19, 50%) reported that they typically consumed alcohol every week. Men were more likely to have consumed alcohol in the week prior to interview (n = 16, 53%) than their female counterparts (n = 3, 38%). Analysis also revealed that those who reported drinking alcohol in the week prior to interview were slightly older (32.8 years) than those who had not (28 years).

Of the 19 clients who reported drinking alcohol in a typical week, on a typical occasion they consumed on average 16.4 alcoholic drinks. However, these results are skewed by one respondent who claimed he drank 45 drinks a day (40 cans of beer and a naggin of vodka).

From the reported number of drinks on a typical occasion and the number of days a week a person drank, the number of units per week can be calculated. The international recommended drinking levels per week are 14 units for a woman and 21 for a man. Analysis revealed that over a third of the sample (n = 13; 35%) consumed more than the recommended weekly limits of alcohol. This is higher than the 29% who were found to drink beyond recommended limits in Holohan's (1998) study. Male respondents reported consuming a mean of 70 units per week, while female respondents reported consuming a mean of 57 units per week.

TABLE 5.2 DRINKING STATUS OF SERVICE USERS [7]

Drinking Status	Number	Percentage
Abstainer in the past year	8	22
Occasional	10	27
Light	4	11
Moderate	2	5
Fairly Heavy	2	5
Heavy	3	8
Very heavy	8	22
Total	37	100

Missing values: 3

The above table highlights that over a fifth of those who consumed alcohol were very heavy drinkers (n = 8, 22%). Overall, more than a third of the sample (n = 13, 35%) were categorised as fairly heavy - very heavy drinkers. Those sleeping rough or living in a squat were more likely to be heavy/very heavy drinkers. These findings are consistent with theories that drinking is often part of street culture (O'Leary, 1997). Irish research has found that street drinkers are the most marginalised people in Irish society with a range of needs (Costello and Howley, 1999).

5.4 Drug Use

Clients were asked if they have ever used illicit drugs (including cannabis, amphetamines, cocaine, heroin, hallucinogens, LSD and ecstasy). The vast majority (n = 36, 90%) reported lifetime use of drugs. This is much higher than the lifetime use of drugs in other Irish studies on homelessness (Holohan, 1998; Feeney et al, 2000; Houghton and Hickey, 2001). However, this may be due to the fact that some drug users at Fáiltiú may have accessed the service through the Merchants Quay Drugs Project.

Respondents who reported lifetime use were also asked at what age they first used drugs. Figure 5.8 illustrates that 88% (n = 28) of the clients were teenagers when they first used drugs. The mean age for first using drugs

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[7] The alcohol consumption rating was calculated by multiplying the number of units of each type of drink consumed on a 'usual' day, by the number of days a week the person 'usually' drank. One unit of alcohol was measured as half a pint, a single measure of spirits, a glass of wine and a small glass of sherry or fortified wine. The respondents were classed into the following categories (taken from the OPCS study, 1996) based on their usual weekly consumption (units) of alcohol over the last twelve months: abstainer in the past year (respondent drank no alcohol); occasional drinker (under one unit per week); light drinker (1-10 units per week); moderate drinker (11-21 units per week); fairly heavy (22-35 units per week); heavy (36-50 units per week); very heavy (51 or more units per week).

was 15 years (mode $=12$ years; median $=13$ years). These findings are similar to other studies carried out among homeless drug users (Cox and Lawless, 1999). There was a wide age range, ranging from 9 years to 32 years. Although not significant, analysis revealed that male clients started using drugs earlier (mean $= 14.9$ years) than female clients (mean $= 15.8$ years). These results are also consistent with studies on homeless drug users (Cox and Lawless, 1999).

FIGURE 5.8 AGE FIRST USED DRUGS
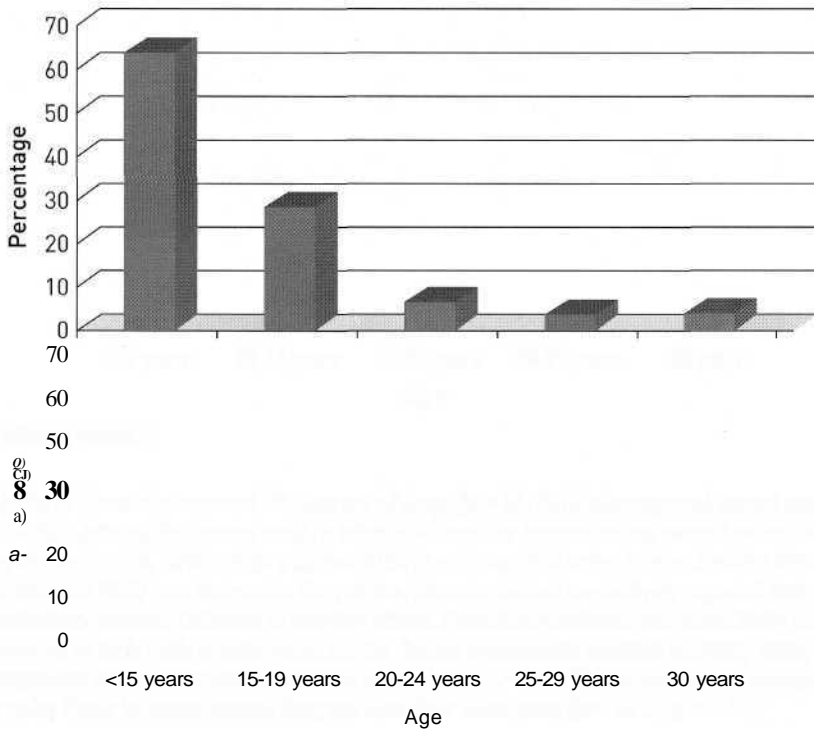
Missing values: 4

The vast majority of those who reported lifetime use of drugs (n = 29, 85%) also reported current use of drugs (i.e. in the last 4 weeks). Among the current users, a substantial number reported using prescribed methadone as their primary drug of use (n = 13, 45%) while a further 31% (n = 9) reported using heroin. Another three respondents reported that cannabis (8%) was their main drug of use. One respondent respectively reported their primary drug was street methadone, cocaine, Dalmane or sleeping tablets. Female respondents were more likely to report current drug use compared to their male counterparts. All the female respondents reported currently using drugs (n = 8, 100%) in comparison to three-quarters of the male respondents (n = 20, 77%). Furthermore, younger clients were significantly more likely to report current drug use than their older peers (z = -2.13, p < 0.05).

Among those who used heroin the vast majority injected it (n = 8, 89%) while one person reported skin-popping.[8] The respondents were asked how often they used their primary drug in the four weeks prior to interview. Among those who used heroin, two-thirds (n = 6, 67%) took it 4 or more times a day while the other 3 respondents (33%) took it every day.

Twenty-four respondents reported using a secondary drug. In other words, 63% of the total sample were polydrug users. This is higher than the level of polydrug use reported in previous studies (Cox and Lawless, 1999; Houghton and Hickey, 2001). Among the polydrug users the most popular secondary drugs were cannabis (n = 8, 33%) followed by heroin (n = 5, 21%) and benzodiazapines (n = 5, 21%). Those who reported heroin as their primary drug of choice were more likely to report cannabis as their secondary drug of choice. Those who were on prescribed methadone were more likely to report cannabis, benzodiazepines or heroin as their secondary drug of choice. Female clients (n = 7, 88%) were more likely to report secondary drug use than male clients (n = 17, 65%). Furthermore, those who reported secondary drug use were significantly younger (28 years) than those who did not report polydrug use (36.8 years) (z = -2.99, p < 0.05). It is important to note that overall 14 people (37% of the total sample) were taking heroin, 9 as their primary drug of use and 5 as their secondary drug of use.

needle exchange in Merchants Quay are homeless and also frequent the Fáiltiú Resource Centre. Figure 5.9 illustrates the age at which clients initiated intravenous drug use.

FIGURE 5.9 AGE FIRST INJECTED
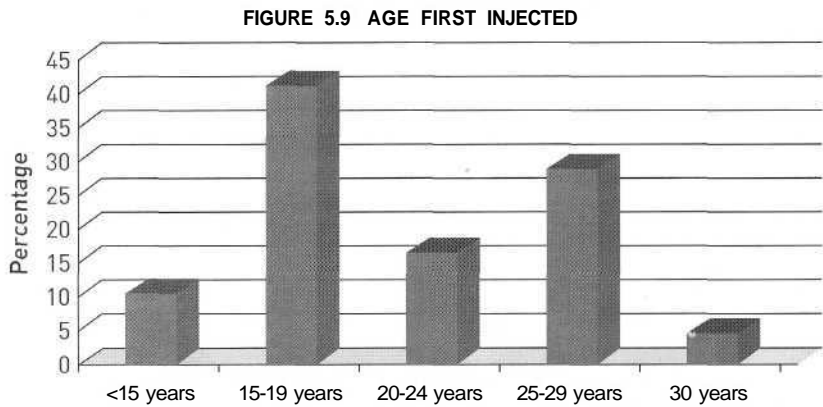
Missing values: 4

The above figure reveals that a substantial number of those who had injected, started injecting between 15 and 19 years (n = 12, 41%). However 3 respondents (10%) injected before they were 15. Almost a fifth of the respondents (n = 5, 17%) reported initiating intravenous use in their early 20s, while over a quarter (n = 8, 28%) began injecting between 25 and 29 years. The following graph shows how long respondents were intravenous drug users.

FIGURE 5.10 LENGTH OF TIME INJECTING
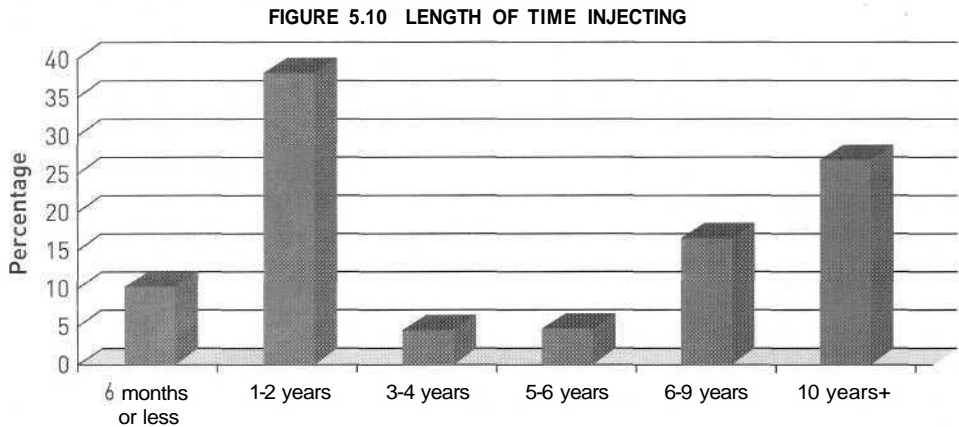
Missing values: 4

Analysis revealed that among those who had been injecting, more than a third (n = 11, 38%) had been injecting for between 1 and 2 years, while a further 27% (n = 8) had been injecting for more than 10 years. Although not significant, male clients reported injecting careers twice as long as female clients (7.7 years vs. 3.8 years). Overall, these findings are similar to Cox and Lawless' (1999) study on homeless drug users.

Among those who had injected, almost half were no longer injecting (n = 13, 45%). Among those who were still injecting (n = 16, 55%) the majority reported injecting every day (n = 10), 2 respondents reported injecting every week, while a quarter reported injecting every month (n = 4).

5.5 Physical Health

Respondents were asked about their perceptions of their health status and what conditions, if any, they were suffering from. The following table shows the respondents' perceptions of their health.

TABLE 5.3 PERCEPTIONS OF HEALTH

Health Status	Number	Percentage	Cumulative Percentage
Very poor	5	13	13
Poor	13	34	47
Fair	10	26	73
Good	4	11	84
Very Good	6	16	100
Total	38	100	100

Missing values: 2

The above table shows that almost half the respondents (n = 18, 47%) perceived their health as poor/very poor. While there was no difference between age or gender and perceived health status, rough sleepers were more likely to consider their health poor/very poor. This is not surprising as British research has shown that the health status of people sleeping rough is worse than that of other homeless people (Anderson *et ah,* 1993; Bines, 1994).

All of the respondents reported suffering from one or more physical complaints, while over two-thirds of the respondents (n = 25, 66%) were suffering from 5 or more complaints. The mean number of conditions reported was 6 (range = 2-13). The respondents who perceived their health as poor/very poor reported significantly more physical complaints (z = -2.26, p < 0.05). The number of respondents experiencing at least one complaint and the average number of complaints is higher than in previous studies carried out among homeless populations in Ireland (Holohan, 1998; Feeney *et ah,* 2000).

The physical complaints are listed in Table 5.4 in order of decreasing frequency. None of the respondents reported suffering from diabetes, heart disease or emphysema.

Fhe table reveals that almost three-quarters of the respondents were suffering from dental problems or leadaches. Condon (2001) conducted an oral health survey, which included a dental examination, among 234 lomeless people in Dublin. She found that 98% of those examined needed dental treatment. A substantial lumber of the respondents also reported suffering from colds and flu, Hepatitis C, problems with bones and oints, eye and ear complaints, foot problems, Peptic Ulcer Disease and/or arthritis. All of those who had hepatitis C had been, or still were, injecting drug users.

^ess than half the sample had been vaccinated against Hepatitis B (n = 18, 47%). Female clients were more ikely to have been vaccinated compared to their male counterparts (57% vs. 43%). This is worrying as iepatitis B is a common and serious preventable illness among homeless people (Condon *et ah,* 2001).

[7]emale clients were asked if they had undergone a smear test or a breast examination in the last three months. Phe results were very low. Only one female client (13%) had undergone a smear test in the last 3 months while 10 one had undergone a breast examination. This is consistent with the findings of Smith *et ah* (2001), as they bund that gynaecological and obstetric screening measures failed to reach a high proportion of the 100 lomeless women they interviewed.

TABLE 5. *k* FREQUENCY OF HEALTH COMPLAINTS AMONG
SERVICE USERS

Condition	Number	Percentage
Physical symptom		
Headache	28	74
Colds and flu	26	68
Problems with bones and joints	18	47
Eye and ear complaints	16	42
Foot problems	13	34
Skin complaints	8	21
Dental Health Problems		
Dental Problems	28	74
Chronic physical health problem		
Hepatitis C	19	50
Peptic Ulcer Disease	12	32
Arthritis	12	32
High Blood Pressure	10	26
Asthma	10	26
Hepatitis B	6	16
Bronchitis	5	13
Rheumatic Disease	5	13
Jaundice	4	11
Epilepsy	3	8
Tuberculosis	1	3
Other Complaints		
Other	7	18

Missing values: 2

5.6 Psychological Well-being

The levels of reported mental health complaints were extremely high. Almost all the respondents (n = 37, 97%) reported suffering from a mental health complaint during the 3 months prior to interview. These are displayed in the following table.

TABLE 5.5 MENTAL HEALTH COMPLAINTS

| Health Complaint	Number	Percentage
Depression	34	90
Anxiety	30	79
Unable to Cope	28	74
Feeling isolated	28	74
Suicidal	20	53
Hearing things	8	21

Missing values: 2

The table shows that the vast majority of respondents (n = 34, 90%) had felt depressed in the 3 months prior to interview while over three-quarters had been feeling anxious (n = 30, 79%). The reported rate of depression is extremely high compared to other studies (Holohan, 1998; Feeney, *et al,* 2001). Other studies that have used

)jective measures for depression have found lower rates. For instance, Condon *et al.* (2001) found that 46% reened positively for depression among the homeless people they examined. Almost three-quarters of the spondents had also felt unable to cope and isolated. More than half the sample (53%, n = 20) had felt licidal. Although this figure is a cause for concern, it is not quite as high as the 68% who had made a serious licide attempt in Cleary's (1998) study. Analysis revealed that women were more likely to report mental :alth complaints than their male counterparts. This is consistent with findings from other studies (Cox and iwless, 1999). While this may be due to a real gender difference, it may also be due to the fact that women e more likely to admit to suffering from such conditions (Cox and Lawless, 1999).

lie following figure displays the percentage of those assessed or diagnosed with a psychiatric illness.

FIGURE 5.11 PERCENTAGE OF SERVICE USERS DIAGNOSED WITH A PSYCHIATRIC ILLNESS
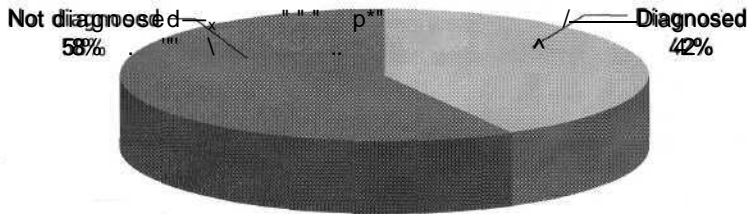
Missing values: 2

igure 5.11 shows that more that 42% (n = 16) of the respondents had already been diagnosed as suffering ith a psychiatric illness. Among those who had been assessed as suffering from a psychiatric illness, over ilf were diagnosed as being depressed (n = 8, 53%) while over a quarter (n = 4, 27%) had alcohol ^pendency. A further 2 respondents were schizophrenic.

'espite the high levels of psychiatric problems, only 11% (n = 4) were linked with psychiatric services. This less than half those who reported being in contact with psychiatric services in Cleary's study (1998). owever, in the past over a third had been admitted to a psychiatric hospital (n = 13, 35%). This is slightly >wer than the 40% in Cleary and Prizeman's study (1998). More male clients than female clients had been imitted to a psychiatric hospital (40% vs. 14%). A substantial number of those who had spent time in a sychiatric hospital had been admitted for depression (n = 4, 31%) while almost a quarter had been admitted scause of a nervous breakdown (n = 3, 23%) or alcohol dependency (n = 3, 23%). Other reasons were for Aizophrenia or overdose.

.7 Health Services

•nly less than half the clients (n = 18, 47%) reported having a medical card. This is less than that reported in ther studies (Feeney *et al,* 2000). Half of the male respondents reported having a medical card (n = 15, 50%) 'hile just over a third of the female respondents (n = 3, 38%) reported having a medical card. Those who were l possession of a medical card were significantly older than those who did not have one (z = -2.314, p < 0.05). he average age of those who had a medical card was 33.7 years, while those who did not have a card had an verage age of 28.1 years. Among those who had a medical card, 38% received their card through the Health iOard (n = 7), while over a fifth either applied for the medical card themselves (n = 4, 22%) or through the áiltiú Information and Advice Service (n= 4, 22%). Others applied for a medical card through their GP, a entist or work.

luring the three months prior to the interview, the vast majority of the respondents (n = 34, 90%) had been in ontact with health services. This is higher than in other studies on homeless populations (Feeney *et al,* 2000). LI of those (n = 18, 100%) who were in possession of a medical card had been in contact with the health ;rvices, while 80% (n = 16) of those who did not have a medical card had been in contact with health services, herefore, it would seem that clients are less likely to contact health services if they are not in possession of i medical card. All of the female respondents (n = 8, 100%) and the majority of males respondents (n = 26,

87%) had been in contact with the health services. The different services the respondents were in contact with are displayed in the following graph.

FIGURE 5.12 CONTACT WITH HEALTH SERVICES
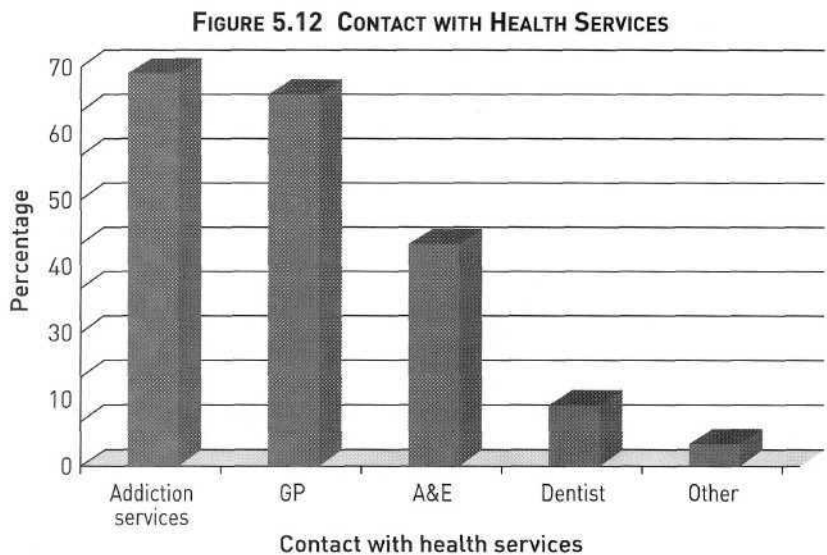
Missing values: 2

The above graph shows that over two-thirds (n = 26, 68%) had been in contact with addiction services during the three months prior to interview. Current drug users were significantly more likely to be in contact with addiction services (df = 1, p < 0.005). The vast majority of current drug users (n = 25, 89%) were in contact with addiction services. These results are reassuring compared to Holohan's (1998) study, as he found addiction services were underused as 68% of drug users were not in contact with them.

A substantial number (n = 24, 63%) had also been in contact with their GP. Over a third of the respondents had been to A&E (n = 15, 40%), while 9 respondents (24%) had visited an outpatients clinic. Only 5 of the respondents (13%) had seen a dentist. Although not significant, those who visited the dentist were more likely to have a medical card while those who went to an outpatient's clinic, A&E and addiction services were less likely to possess a medical card. Younger clients were more likely to have been to see a GP or contact addiction services while older clients were more likely to have been to a dentist or an outpatient's clinic. A higher proportion of female clients than male clients had been to a dentist, GP or addiction service.

5.8 Discussion

The response rate (51 %) for this study was quite low. However, low response rates are common in research carried out with homeless populations (Houghton and Hickey, 2001). Many homeless people may feel that being asked to express their views or become involved in service provision may seem too ambitious or unimportant in comparison with their more pressing immediate needs (Cooper, 1997). Furthermore, service users may view research as futile if expectations had been raised in the past about service provision and nothing changed (Cooper, 1997).

Demographic Profile: The vast majority of service users were Irish and all of them were from Ireland or the UK. Although no respondents reported being refugees or non-EU nationals other studies have found that refugees make up 15% of the homeless sample (Holohan, 1998). This indicates that refugees and non-EU nationals, despite their homeless status, may not be accessing homeless services.

The majority of the respondents identified themselves as single, which indicates that they may be lacking the necessary social support to help them obtain independent living outside the homeless circle. These findings

are consistent with British research which has found that lone parents and single males are most likely to experience homelessness (Burrows, 1997). Furthermore, this research also found that homelessness is relatively rare amongst people who are currently married or who have been widowed (Burrows, 1997).

More than two-thirds of the respondents had children. A recent study found that homelessness is a particularly difficult experience for children (Halpenny et al, 2001). Homeless children often find living in emergency accommodation constraining and mothers feel pressurised in finding time and space for their children. This study also found that while some children were attending school regularly, others were not due to having to move accommodation frequently and homelessness was reported to have had a negative impact on the children's behaviour (Halpenny et al., 2001).

Half of the respondents were early school leavers while 45% had no qualifications. Research in the USA has found that perceived need and higher levels of educational attainment are positively associated with the use of medical, mental health and drug treatment services by homeless people (Padgett et al, 1990). This indicates that service users of Fáiltiú may be less likely to access such services. Furthermore, people ending full-time education early may end up becoming long-term unemployed because they are unskilled, inexperienced and unmotivated (Kennedy, 1999). Moreover, three-quarters of the respondents were unemployed. Daly (1993) found in her analysis of data from different European countries that in general low educational qualification levels were related to poor employment records. Unemployment is persistently seen as a major contributory factor to homelessness (Greve, 1999) as it makes it difficult for homeless people to compete in the housing market (Homeless Agency, 2001). Also, those respondents who are not participating in the labour force may be isolated from peer groups for information on employment and training programmes.

As there is often no support for those discharged from prisons, ex-prisoners are often at risk of becoming homeless and falling into a pattern of criminal recidivism. Therefore, it is not surprising that nearly two-thirds of the sample had been in prison at some point in time. Lack of advice and assistance to people leaving institutions, such as prisons, has been cited as barriers to obtaining accommodation (Carlisle, 1997).

Experiences of homelessness: More than two-thirds of service users (67%) reported having experienced homelessness more than once. This indicates high levels of episodic homelessness and indicates that people have difficulties managing on their own due to lack of support services. The most frequently reported life event that preceded homelessness was family conflict. Houghton and Hickey (2001) found that family conflict and relationship problems constituted the most significant contribution leading to homelessness. Similar findings have been found in Britain (Greve, 1997). The multitude of causes of homelessness shows that it cannot exclusively be explained by either structural or individual factors.

Alcohol Consumption: While the number of regular drinkers was lower than numbers in other studies on homeless populations (Feeney et al, 2000) and national surveys (Friel et al, 1999), there was a substantial number of individuals (35%) who consumed alcohol beyond the recommended limits. One way of reducing the harm related to alcohol consumption among homeless people are 'wet' hostels, i.e. hostels where people can consume alcohol on the premises (Costello and Howley, 1999; Pleace and Quilgars, 1996). Counselling for alcohol use is also considered an integral part of such a service to help homeless people manage their alcohol consumption more moderately (Costello and Howley, 1999; Pleace and Quilgars, 1996). While Pleace and Quilgars (1996) also feel that there is a need for more detoxification facilities specifically targeted at homeless people, McCarthy et al (1991) argue that detoxification is not sufficient in itself. Treatment programmes also need to look at related problems of lack of housing, job skills and social support. Therefore any detoxification programme targeted at homeless people would need to adopt a holistic approach. After detoxification homeless people need 'safe and sober housing to continue a successful recovery' (McCarthy, 1991: 1144).

Drug Use: The vast majority of service users were currently using drugs. According to O'Higgins (1998), drug use and homelessness are intuitively linked and housing issues and drug problems are 'intimately (if not causally) related' (6). Respondents were not asked about risk behaviour and drug use although 86% of those who had used drugs reported injecting drugs at some time during their drug using career and 44% were currently injecting. Homeless drug users are at risk of sharing injecting paraphernalia and borrowing used injecting equipment (Cox and Lawless, 1999). Furthermore, they also risk using more drugs as a result of

being homeless (Cox and Lawless, 1999). The high level of drug use among this group implies th; information is needed on safe drug use as well as addiction services. Furthermore, drug use will also impa< on the information needed on housing and resettlement. Moreover, opiate users attending Fáiltiú should b linked in with the Merchants Quay Drug Services.

Health Status: As a result of living in inadequate housing, which is often over-crowded and damp, homeless peop] in Ireland have more health problems than the general public (Holohan, 1998). The same is true of homeles populations in Britain (Connelly, and Crown, 1994; Pleace and Quilgars, 1996; Bines 1997) and America (Fische and Breakey, 1991). Almost half the respondents (47%) reported their health as poor/very poor. Surprisingly n respondents cited health problems as a primary or secondary reason for homelessness. This might indicate the homeless people are at increased risk of developing health problems. All the respondents reported suffering fror at least one physical complaint which is higher than the 68% in Holohan's (1998) study and the 91% in Feeney *i al's* (2000) study. Similar to these studies, dental health complaints were extremely common. Half the responded reported having Hepatitis C, compared to 5% in Feeney *et al's* (2000) study. All those with Hepatitis C in this stud had been, or still were, injecting drug users. This is not surprising as Hepatitis C, can be spread very readily b sharing needles and syringes (Smyth *et al,* 1999). Feeney *et al's* (2000) study may have excluded injecting dru; users as the respondents were hostel-dwelling men and many hostels have a 'no drugs' policy. Other studies hav found that health promotion literature is not reaching homeless people (Birkbeck and Linehan, 2001) and thi should be addressed by the Information and Advice Service.

Psychological Well-being: The mental health complaints among this sample were extremely high. This i consistent with other studies such as Anderson *et al.* (1993) who found that eight times as many people ii hostels and B&Bs and eleven times as many people sleeping rough reported mental health problems comparec with the general population. Some commentators believe that the deinstitutionalisation of psychiatrii hospitals, leading to community based treatment, has increased the number of homeless people (Ginnety *et al.* 1995; McKeown, 1999). British commentators have also noted that homelessness can also cause mental healtl problems (Connelly and Crown, 1994; Pleace and Quilgars, 1996). This is due to the stress related t(homelessness such as 'uncertainty about the future, poor housing conditions or overcrowding' (Connelly anc Crown, 1994: 34).

Contact with Health Services: The number of clients with medical cards was lower than in other studies or homeless populations (Holohan, 1998; Feeney *et al,* 2000). This is a cause for concern as the results indicated thai those with medical cards were more likely to be in contact with health services. Feeney *et al.* (2000) found thai the most common reason for lack of a medical card could be attributed to lack of knowledge about eligibility oi about how to get a medical card. In order to ensure equity of access to primary health services, staif at the Information and Advice Service need to identify individuals without medical cards and help them through the application process. Over two-thirds of the service users had been in contact with addiction services. This is probably due to the close proximity of the Merchants Quay Drugs Project. Almost two-thirds of the service users had been in contact with a GP in the last three months. It is especially important for homeless people to be registered with a GP as it is often the GP who is the gateway to more specialised services. More service users had been in contact with GPs than with A&E which contradicts the view that homeless people are more likely to go to A&E than more appropriate settings. This finding is consistent with Feeney *et al.* (2000). Feeney *et al.* (2000) advised that primary care teams should be introduced in inner-city Dublin aimed at improving the health and social well-being of the homeless through the provisions of integrated care and at linking people into mainstream services.[9] This they felt would prevent the inappropriate use of A&E. Almost a quarter of the service users had been in contact with Outpatients Clinics which is consistent with other research (Feeney *et al,* 2000). However, Feeney *et al.* (2000) found that a primary health care team would be better suited to homeless persons' needs. This would avoid difficulties in accessing Outpatients Clinics which include being unlikely to be seen by a doctor to whom they were referred, long waiting times and difficulty getting there (Feeney *et al,* 2000). Despite almost three-quarters of the clients reporting dental problems, only 13% had been to a dentist in the last 3 months. Condon (2001) recommended that staff working in Information and Advice Services for homeless people should provide information on accessing medical and dental services to help people access dental treatment.

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[9] A primary health care service is being set up at the Fáiltiú Resource Centre in 2003.

Evaluation Data

This chapter presents the data collected from the 40 service users who completed the evaluation of the Fáiltiú Information and Advice Service.

6.1 Evaluation of Information and Advice Service

The majority of clients (n = 28, 70%) reported that they preferred to find out information by asking other people and over half (n = 23, 58%) also liked to find out information for themselves. Female clients and young people were more likely to prefer to find out information through other people. Some of the older male clients explained that they did not want to talk about their personal problems with a member of staff. It transpired in the focus group discussion that some service users did not make known their needs to the staff.

> *The key workers need to chat to people to see what they want. The workers need to ask some people, as some are too shy to ask.*

> (Male client, 50 years)

FIGURE 6.1   MEANS OF RECEIVING INFORMATION
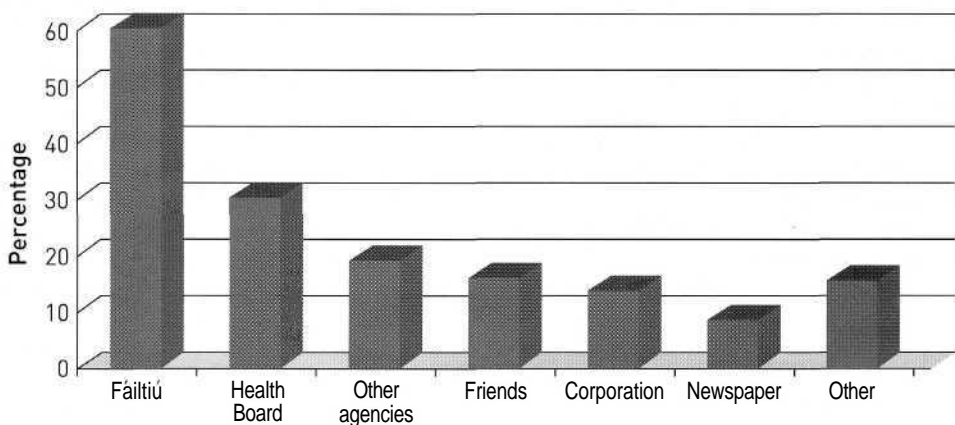
Figure 6.1 shows that the majority of clients (n = 24, 60%) received information on housing, social welfare and health issues from the Fáiltiú Information and Advice Service.[10] Almost a third of the clients (n = 12, 50%) received this kind of information from the Health Board, while 7 respondents (18%) reported receiving information from other homeless services. Six clients (15%) approached their friends for information, while five (13%) went to Dublin City Council for information on housing, social welfare and health issues.

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[0] This is probably due to sampling bias.

Pieces of the Jigsaw

Only three respondents (8%) used newspapers as a means of finding information and no one reported us television or the Internet to gain information. Younger clients were more likely to report using the Fáil Information and Advice Service whereas older clients were more likely to use their friends or newspapers, relation to gender differences, male clients were more likely to use newspapers, friends and the City Coun for information, whereas female clients were more likely to use the Fáiltiú Information and Advice Servia

Over half the clients who attended the Fáiltiú Information and Advice Service (n = 22, 55%) heard aboui through their friends. A quarter of the clients (n = 10, 25%) heard about Fáiltiú through workers in otl services while the remainder heard about Fáiltiú through their family, Fáiltiú workers, leaflets, social works or the Franciscans.

FIGURE 6.2 USE OF FÁILTIÚ INFORMATION AND ADVICE SERVICE
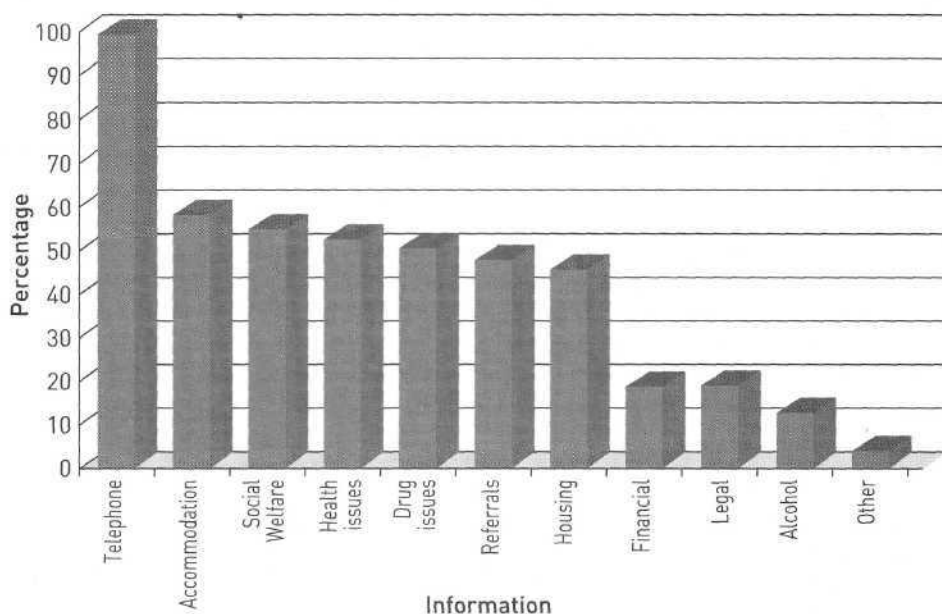

Figure 6.2 above shows that 98% (n = 39) of clients asked to use the telephone at the Information and Advice Service to access the Homeless Person's Unit and similar agencies. Over half the clients used the Service for information on emergency accommodation (n = 23, 58%), social welfare (n = 22, 55%), health issues (n = 21, 53%) and drug issues (n = 20, 50%). A substantial proportion of clients also requested information on referrals (n = 19, 48%), housing (n = 18, 45%), financial issues (n = 7, 18%) and legal issues (n = 7, 18%). Only 5 people (13%) used the Service for information on alcohol issues while one person had asked about childcare issues.

Those who asked for information on referrals to other agencies were significantly younger (z = -2.062, p < 0.05). Although not significant, those who sought information on emergency accommodation, social welfare and drug issues also tended to be younger. Only male clients asked for information on alcohol issues and more male clients tended to ask for information on health issues. Female clients were more likely to request information on social welfare, drug issues and referrals to other agencies.

The clients were asked if they had any difficulties in requesting information in Fáiltiú. The vast majority of clients (n = 36, 90%) did not have any problems, as one client stated:

> *The staff are very open and if they don 't know the information they 'll find someone who does and try and locate them.*

(Male client, 34 years)

However four clients (10%) complained that they had to repeat their story several times to different staff members. Two clients mentioned that they had to queue to talk to staff while another two clients complained that there were no rooms available to discuss information. Other barriers to requesting information mentioned were that the staff were too busy or there was not enough time.

Only 5 respondents (13%) reported that information they requested was not available. The gaps highlighted were information on health, aftercare, accessing deposits for flats, dealing with statutory agencies and organising workshops in Fáiltiú.

Almost half of the respondents (45%) cited different kinds of information they would like to see available. Nearly one fifth of the respondents (n = 7, 18%) requested more information on housing and applying for social housing. The Service's information on private rented accommodation was criticised, as it does not state whether certain landlords accept social welfare payments. Five respondents (13%) requested more information for rough sleepers, such as night shelters, soup runs, sleeping bags and emergency hostels. Three clients requested information on drug treatment services and counselling services for drug users, while two respondents stated the need for more information on health issues. Other information requested was on shower services, laundrettes and organising activities in Fáiltiú.

Although Fáiltiú Information and Advice Service does not have a one-to-one key worker system available to all clients, almost all of the respondents (n = 37, 93%) would like to see this system established.[11] As two clients pointed out:

> You can build up trust, as it's easier to talk to someone you can trust.
>
> (Male client, 30 years)

> I would like to be able to choose my own key worker, one that understands and one who does not have an attitude. I have dealt with three different people in Fáiltiú and I'd prefer to have one person.
>
> (Male client, 30 years)

However, some staff members felt that the fact that many of the staff work part-time would make introducing a key working system problematic.

> Rl The other thing is there are very few people who work five days a week. People who are keyworking actually often work half days so people aren't there on a constant basis whereas other people may only do two days. So if a couple or an individual wanted the same key worker it could be quite difficult to manage to meet once a week, whereas other workers could follow on.
>
> (Full-time project worker)

> RIO Yeah, a lot of the people would not be good at making an appointment and staying.
>
> (Full-time project worker)

Conversely, the fact that some of the staff worked part-time was not an issue for the clients:

> R2 You're goin' to know what days they're on. If you've got them they're goin' to tell you what days they're on, you know what I mean.
>
> (Male client, 30 years)

The amount of knowledge needed for keyworking was raised as a particular challenge by staff:

> RIO It takes a lot of knowledge and skill to be able to keywork an individual or a couple because it's huge. There's a lot of people involved in keyworking where people count on their knowledge could be courts, could be social workers, could be probation officer so you're

---

[11] Key working involves providing consistent support to individual clients and preventing vulnerable people who use the service from slipping through the net. If used properly, it can help issues be resolved more effectively.

> *just a support to different agencies so how do you pin yourself down to be able to have proper guidelines to work through all that.*
>
> (Full-time project worker)

Therefore it was suggested that key workers should specialise in different areas.

The clients were asked how contact with workers in Fáiltiú could be improved. Over one third (n = 15, 38%) felt that contact did not need to be improved. As some stated:

> *The system which is set up is all right. It's only a matter of asking.*
>
> (Male client, 40 years)

> */ don't think you could improve it any more. They 're great the way they are.*
>
> (Female client, 27 years)

However, the majority of respondents (n = 21, 62%) felt that contact with workers could be improved. Eleven clients (28%) felt that a one-to-one key worker system would facilitate better contact.

> *If you have a one-to-one key working system you can come in and make appointments.*
>
> (Male client, 48 years)

Eight respondents (20%) felt that interaction with staff was difficult in Fáiltiú as staff are distracted by other clients. Therefore, some clients felt that there was a need for more contact rooms.

> *You need more privacy cos at tables staff are not always listening to you but they are looking round watching other people. There are staff on the floor and they should be in charge of watching people and the staff at tables should talk to people. Sometimes they don't listen or say I'll get somebody else to come over.*
>
> (Male client, 30 years)

Staff also agreed that lack of resources impeded their contact work with clients.

> *Rl But it is also about the resources, you know. You could be sitting talking to somebody who 's in real dire needs at the table but you 're watching somebody maybe who 's trying to pass something over here, so you're not giving it a 100%. So it's about the resources we have as well.*
>
> (Full-time project worker)

The respondents cited several other factors which hindered contact with workers. These included the fact that not all workers initiate conversation, some clients had a problem with the attitude of some staff members and others felt that some staff members did not understand their situation. This is illustrated by the following comments:

> *The attitudes of some people need to change. Some people are there because they want to be seen to help the homeless. There should be no falseness.*
>
> (Male client, 30 years)

> *There's certain staff over there, I'm not goin' to mention any names, who seem to treat it like a power trip. There is that attitude and that attitude shouldn 't be there. They 're dealin' with homeless people and they 're on a power trip.*
>
> (Male client, 30 years)

> *You need to make sure that a person knows you and how out of touch you are and how your life is disintegrating into nothin'. [...] You need to give people jobs who understand what you are goin' through.*
>
> (Male client, 38 years)

Three respondents (8%) felt that further training would be beneficial for staff members especially in relation to psychiatric problems and drug use.

> *The staff can't deal with upset and this makes me angry. I find people judge you before they come to you and that's wrong. It makes me think what do they take me for. I find people sometimes talk to you and they 're thinking you don't know nothing. The workers need to be trained on different issues like how to deal with depression. Sometimes I say I don't feel right today and next minute they get up and walk away. Fáiltiú workers sometimes don't listen to you or they say I'll get somebody else over.*

> (Male client, 30 years)

The staff also felt that while they receive regular training in personal development, staff orientation and computer training, there were gaps in their knowledge.

> *RIO We're not completely 100% with our information and advice and that creeps in and the clients think I'll go up to Focus, I'll be able to get my information there, because they don't know it here in Failtiu. I mean we see people giving inaccurate information and I've done it myself from time to time, we need to get on top of that and say, no we do have the information, you know and that carries a lot more weight with service users.*

> (Full-time project worker)

The staff also thought they needed more training, especially in relation to referrals and legal issues.

> *RIO Once I was keyworking a couple and the legal implications came up one time that I might have to go to court about a case on sexual abuse and that can be difficult and there's no sort of guidelines for that yet so we'll have to look at that. [...] What are the guidelines for referral etc? For example you know what Aids Alliance does but how does it relate to what's going on on the floor, how do you make a referral there, you know, what is the procedure, what are the clients going to gain from this, you know that kind of sense of awareness.*

> (Full-time project worker)

> *R3 I think there is more room for training in what kind of accommodation is available, what it's like and what we're sending them to and that type of thing, I'm talking for myself as other people may be more aware and then you 'd begin to get to know when you 're talking to the clients what certain hostels are like, what it provides, when they come out of it for example and just more of that type of training for me would even be extremely important.*

> (Volunteer)

Furthermore, the staff also discussed the difficulties in accessing different information resources and many of them pointed out the benefits of having an Information and Advice Officer to help them access information.

> *Rl There's no training in how to actually use the books, you 're depending on the team's initiative to take time out and read two books and for a team of 40 you 're looking at two books between those 40 to pick and read.*

> (Full-time project worker)

> *RIO We need to know how to access the information. There is a lot of information and it's great that we 've got it in but there are loads of books, you know, the same information in the same book, it may be hard to find it. Even looking up places, if you didn 't know the name of a place but if you know what category it was under, grand you could look it up.*

> (Full-time project worker)

Finally, it was also highlighted that staff needed training on how to deliver information.

Pieces of the Jigsaw

RIO Also on a more practical aspect like we haven't done counselling and listening skills in a long time, basic skills that improve the quality of listing information, to use it in a safe way and we haven't done that in a long time.

<div align="right">(Full-time project worker)</div>

Almost two-thirds of the respondents (n = 24, 60%) had taken leaflets from Fáiltiú. Among those who had not taken leaflets two respondents remarked:

I've never seen any leaflets

<div align="right">(Male client, 44 years)</div>

I didn't think there was any.

<div align="right">(Male client, 35 years)</div>

Therefore, clients recommended that leaflets were more accessible.

You should be able to have leaflets at hand rather than have to ask for them. Some people don't like to ask.

<div align="right">(Male client, 40 years)</div>

All those who had taken leaflets (n = 24, 100%) reported that they were useful. Among those who had taken leaflets, 29% (n = 7) had taken some on other organisations, and a quarter (n = 6) had taken leaflets on Hepatitis C. Other information sought by the respondents was on Dublin City Council, drugs, STDs, NA meetings, hostels, food centres, personal development courses and services for rough sleepers. Some staff members and clients felt that leaflets needed to be written in a simpler and clearer style, especially for those with literacy problems.

R8 Well I would say one in regards to leaflets, not everyone can read and write. Some of the leaflets that are produced are very standard and some of the people who come in through the doors of Fáiltiú do not really fall into that category. So I think the information on some of the leaflets needs to be adapted. That's one gap that I would identify.

<div align="right">(Full-time project worker)</div>

Information is often given out through notices and an awful lot of people can't read. They should go round the tables and tell people the information.

<div align="right">(Female client, 34 years)</div>

The clients were asked how they would rate the information on several criteria. The results are displayed in the following graph.

FIGURE 6.3 CLIENTS' PERCEPTIONS OF INFORMATION PROVIDED
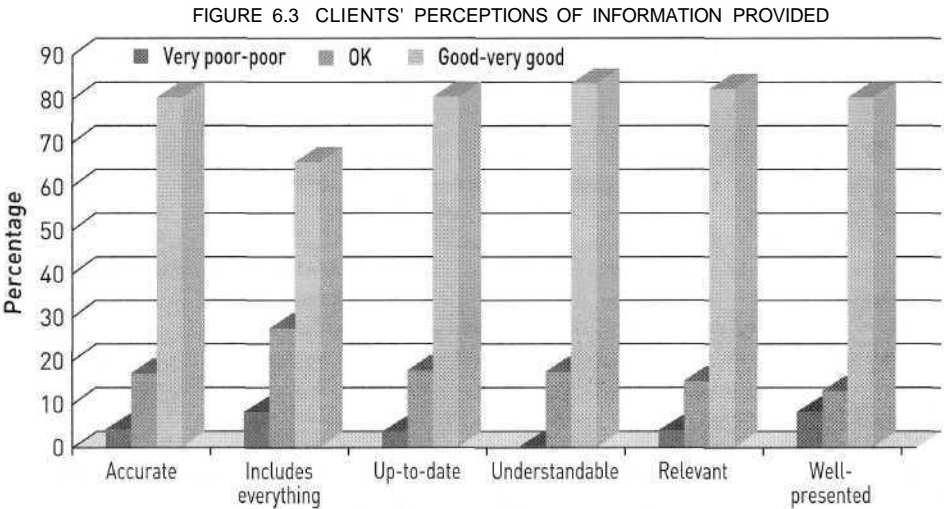
The above graph shows that overall the clients were very satisfied with the information provided. Thirty-two of the clients (80%) reported that the accuracy of the information was good/very good. A similar number also reported that the presentation, relevancy and clarity of the information were good/very good.

The clients were also asked to rate the staff on a scale of 1 to 5. Some of the clients commented that this was difficult, as some staff members were more knowledgeable or approachable than others were. The results are shown in the following graph.

FIGURE 6.4 CLIENTS' PERCEPTIONS OF STAFF
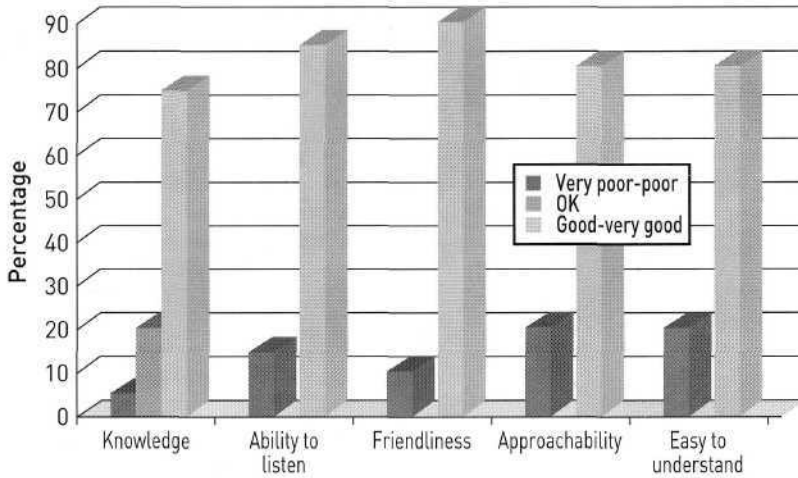
The above graph shows that overall the clients were very satisfied with the staff at the Fáiltiú Information and Advice Service. Over 80% of the clients rated the staff highly on their ability to listen, their friendliness, approachability and ability to communicate clearly. As some clients commented:

> The staff help me. It's a place to go and socialise. You also get a bite to eat. The key workers can help you solve your problems.
>
> (Male client, 42 years)

> / like the staff and they 're friendly. I like the way they make you feel welcome and the help they give you.
>
> (Female client, 30 years)

When asked what they liked about the Fáiltiú Information and Advice Service, 30% (n = 12) of the clients said that they liked to come to talk to staff or their friends. One client stated:

> There's a good atmosphere and there's someone to talk to. Often I come in and just talk to someone.
>
> (Male client, 33 years)

Over a fifth of the respondents respectively (23%, n = 9) said that they like to come to Fáiltiú because "of the atmosphere" and because it was "somewhere to go". This is highlighted by the following comment:

> / like everything about it. It's somewhere to go and kill an hour or two.
>
> (Male client, 35 years)

Other clients liked Fáiltiú because of the food/tea, shower facilities, phones, they saved money and it was useful.

Three-quarters of the clients (n = 30, 75%) felt that the Fáiltiú Information and Advice Service could be improved. Over a quarter of them, (n = 8, 27%) thought that information alone would not address their needs

and workers should act as advocates for individual service users. Part of the advocacy role should deal with establishing stronger links with external agencies. Some clients commented:

> *They should be able to get you accommodation. They gave me a list of flats that wouldn 't even accept social welfare. How useless is that? All they really do is listen. They can't pull any strings. There's nothing you can talk to them about. Some of them think they're just there to pour tea. They 've no power.*
>
> (Male client, 31 years)

> *They should be able to get in touch with people in higher places so when they phone the [HPUJ they get through to a supervisor instead of the phone.*
>
> (Male client, 30 years)

> *Information is no good, it's actions people need. I need to have somebody there who can help me, right, to get off drugs, that's what we need. We don't need information. Information we can get that anywhere. We can read that out of a newspaper for God's sake, we can get that out of a book. We need someone who is goin' to stand up for us, you know what I mean, and help us [...] Information is no good to you if there isn 't somebody that's goin 'to act on it. It's pointless, it is pointless. You could have all the information in the world. I could go across there into the Internet Café and push a button and I could get information on every fuckin'thing the world over and it's no good to me unless there is somebody there to help me ask them. That's the bottom line, that's the bottom line there's nobody to help us. We could talk all day.*
>
> (Male client, 26 years)

While the Information and Advice Service aims to enable people to take control of their own situation, the above service user criticised the ethos behind this:

> */ asked them to get in contact with Trinity Court in Pearse Street and they handed me the phone - you do it! You know they are supposed to carry weight with regards helpin 'you out and gettin 'you on to drug treatment and all this. They 're telling me that and then they hand me the phone and says you do it. They don't listen to the likes of me.*
>
> (Male client, 26 years)

The staff also agreed that advocacy should become an integral part of their job.

> *R5 Well these people don't have the knowledge to know what their entitlements are, we need to advocate on their behalf, we need to start in the service because they can't get in the service.*
>
> (CE Worker, 2 years)

> *R7 I feel there s something lacking because I feel we do a great job here. I think we 've done a marvellous job but I think when you lift the phone to an agency whether it's a hostel, whether it's Charles Street, whether it's the Corporation I feel there's nobody at the other end who knows you. [...] If we could get the services to know us, and to know who we are and what we 're doing and that we 're not just a drop-in.*
>
> (Volunteer, 3 years)

However, this reverts back to the issue of training as the staff pointed out they could only advocate on a client's behalf if they had the appropriate information.

> *R8 If we know somebody s entitlements when we 're talking to the Corporation, certainly the use of information in terms of our phone calls is very important and we can challenge. We need to know the information first, we need to know what somebody's entitlements are because after all we are advocating for people and we can't be put off when somebody says no. If we believe somebody has a right, our job is to advocate and that is what we need information for.*
>
> (Full-time project worker)

According to the staff, the main obstacle preventing them from advocating on the clients' behalf is the attitude of other agencies. Some staff members pointed out:

> *R4 I find to be honest with you that other agencies don't like to help you which is stupid as we 're all in the same thing. [...] You 'll find that other agencies are not properly funded the way we are, don't like to share and don't like you to come down and visit. No this is the way that we do this, we're happy with the way it's working for us and you get a blank wall. [...] And you feel like shaking them you know because we 're all working for the same thing, so why?*
>
> (Full-time project worker)

> *Rl We're making all the links that we can but at the end of the day we need to be able to stand up and say our name and mention the organisation and they say, oh yeah, yeah. They don 'tjust need to know our name they need to know the organisation's name and there has been a slight improvement but it's still not good enough. It's so hard doing contact work when people are saying to you, who are you? Or who do you think you are?*
>
> (Full-time project worker)

Nevertheless, the staff of Fáiltiú also acknowledged that they need to deal with other agencies in a knowledgeable and respectful way.

> *R7 There is a way around and I also think even leaving a little note saying that you 'd be grateful and they don't feel like they're being bombarded at the end of the phone. I think we could watch our tone occasionally.*
>
> (Volunteer)

One worker suggested that stronger links need to be made with the managers of different services.

> *R2 My opinion is that you need to hit the big boys in the big organisations really, you need to invite them over like or the people actually working in your front line, the Corporation - the Housing end of it; bring them over for a visit because there's nothing like seeing it. That makes more of an impact than all the literature. You could also get the customer care people over on a visit.*
>
> (Volunteer)

Some clients (n = 7, 23%) also felt that the Service needed more facilities, especially more rooms for contact work. A fifth of the clients (n = 6, 20%) also felt that the opening times of Fáiltiú Information and Advice service should be extended so that there are no breaks during the day and so that services are offered at the weekend.[12]

Some clients (n = 4, 13%) also felt that more funding would improve the delivery of the Information and Advice Service. The staff also agreed that they were working under serious staff constraints.

> *R4 We don't have the time, we might have all knowledge, and new volunteers coming on board and other people moving on, and part-time project workers coming on board whatever, we don't have the time or the manpower to educate other people, we don't have the staff to do it. From two o 'clock until four thirty, we don't have the manpower to run the service.*
>
> (Full-time project worker)

Staff members also felt the Fáiltiú Information and Advice Service could be improved by establishing a central resource for information. This has also been proposed by the Homeless Agency (2001).

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[12] Since this report was written, the Fáiltiú Resource Centre now opens at 07.15, 7 days a week. It is also open at the weekend - Saturday: 7.15 am - 9.30 am; 10.30 am - 12.30 pm; 2.00 pm - 4.30 pm. Sunday: 7.15 am - 9.30 am; 10.30 am - 12.45 pm; 2.00 pm - 4.30 pm.

> *Rl There is talk of an Information and Resource Centre going up, like the Health Promotion*
> *Unit, particularly aimed at homeless people's needs. So that's just going to make a job for*
> *anybody dealing in Failtiu so much easier because that's going to be specific and it's going*
> *to be a central system, so you're not going to have to try, I mean you're not going to have to*
> *search. But that's all potential.*

<div align="right">(Full-time project worker)</div>

Several other recommendations were made by clients, which did not have direct implications for l
Information and Advice Service. Clients suggested that they should be allowed to use their mobile phones
Fáiltiú, phone calls should be possible without the presence of a staff member, and there should be iru
information targeted at women. Six clients also proposed that there was a need for more security, créc
facilities and more staff. Two problems with policies at Fáiltiú were that people were not allowed to reti
after they left the building and the exclusion policy was inconsistent. Seven respondents commented that th
would like more social activities:

> */ would like more activities such as games or draughts. It's crosswords all the time in there*
> *and I can't read or write so I can 'tjoin in.*

<div align="right">(Male client, 30 years)</div>

Options given were snooker, darts, writing, gym or yoga. Other clients mentioned that they would like me
day trips. One respondent highlighted the need for a nurse/counsellor.[13]

6.2 Discussion

The value and necessity of the Fáiltiú Information and Advice Service has been reinforced by the results
this evaluation. The majority of clients (70%) reported that they preferred to find out information throu
other people and 60% reported that they use the Information and Advice Service at Fáiltiú as their main som
of accessing information on housing, social welfare and health issues. Moreover, the service users repori
that they were able to access a wide range of information at Fáiltiú including information on accommodaté
housing, social welfare, health issues, drug issues and services, referrals, financial issues, legal issues a
services for rough sleepers.

Discussion in the focus group revealed that some clients did not make known their needs to the staff. Ok
clients and male clients were less likely to ask for information.

Over half (58%) of the service users reported that they preferred to find out information by themselves, whi
raises the need for all leaflets to be readily available in Fáiltiú and the feasibility of a touchscreen databc
should be considered. In America, there has been a move towards political activism directed by homelt
people themselves, where they have designed their own newspapers and organised campaigns. These ran
from newspapers sold by homeless people on the streets, to public education campaigns, to e-mail networi
to computerised searches for missing people (Daly, 1996). Furthermore, in various American cities, t
Homeless Action Coalition provides homeless people with free access to the Internet (for job listings) and \
communicating with other homeless individuals and with service providers (Daly, 1996).

Analysis revealed that many of the service users find their friends a good source of information. Over half t
service users heard about Fáiltiú through their friends, while 15% approached their friends for informatk
This is what Katz and Lazarsfeld (1955) would refer to as a 'two-step flow of communication' where ide
seem to flow, (often from radio and print), to opinion leaders and from them to the less active sections of t
population. These 'opinion leaders' are not at all identical with traditional wielders of influence. They <
distributed on every social and economic level and exert great influence on their peers. Further research coi
be useful in identifying and characterising 'opinion leaders' among the homeless population. They could
used to create a word of mouth campaign, which could be more effective than normal informatioi
campaigns. This is what Naomi Klein (2000) refers to as 'viral marketing'. It might also reach homek
people who avoid homeless services.

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[13] A primary health care service is being set up in 2003.

Very few clients used newspapers, and no clients reported using television or the Internet, to access information. According to Narayan *et al.* (2000), lack of information is reinforced by lack of access to communication and information technology, including telephones, Internet, radio, printed material and television.

While the vast majority of service users had no difficulties in requesting information some barriers were cited. These included repeating their story, queuing to talk to staff, lack of rooms for contact work, staff too busy and not enough time. Long periods of waiting have been cited in other studies as strong disincentives to accessing services (Houghton and Hickey, 2001). Clients also reported that they would like more information on housing, applying through the City Council, private rented accommodation, services for rough sleepers, drug treatment, medical and counselling services.

Almost all the service users felt that a key-worker system would reduce difficulties in accessing information. Houghton and Hickey (2001) found that among their sample of long-term homeless there was also a desire for more individual attention from key workers/counsellors. In her study on London boroughs' strategies for assisting homeless people, Firth (1998) found that the most effective projects had key workers who acted as a liaison point for both internal and external contacts, as well as identifying and meeting specific needs. However, one problem that has been noted about the key-worker role in homeless services, that the Fáiltiú Information and Advice Service would need to address, is that it is 'ill-defined, open-ended, unaccredited and unprofessionalised' (Warnes and Crane, 2000: 45).

Overall the service users were very satisfied with the accuracy, presentation, relevancy and clarity of the information provided. However, the questionnaire did not examine how well homeless people understood the information. In his studies of mass culture, Umberto Eco (1995) points out how people, depending on socio-cultural circumstances, interpret messages and information in a range of different ways. Further qualitative research should therefore examine how homeless people view their world and describe it.

> To understand what the others understand can serve to get them to understand what is understood by other groups whose grammar they are ignorant of. Getting them to understand the language of those who would want them mute as well as the language of those considered mute in the same way as themselves (Eco, 1995: 140).

Overall the service users rated the staff highly on their ability to listen, their friendliness, approachability and ability to communicate clearly. However, some clients felt that staff did not initiate conversations with service users, some clients had a problem with the attitude of some staff members and others felt some staff members did not understand their situation. Houghton and Hickey (2001) found that there was a feeling that some people who work with homeless people need to change their attitude. Both the staff and service users felt that the staff could benefit from further training.

The main recommendation made by service users was that they would like Fáiltiú staff to advocate for individual service users. The Fáiltiú Resource Centre is linked in with a wide range of homeless agencies through the Homeless Network and other agencies providing daytime services for homeless persons. It also has links with other statutory and voluntary providers of services for homeless people through the Homeless Agency. These links are used to inform other agencies about Fáiltiú and to obtain appropriate information. This is particularly important for following through on referral and advocacy work. However, the results from the evaluation would indicate that these links are not as well established, as service users would hope.

Research on homeless services indicates that day centres which establish effective links with other voluntary and community organisations and with local statutory services meet the needs of their service users more effectively (Cooper, 1997; Warnes and Crane, 2000). Cooper (1997) would advise that day centres should not work in isolation but work in partnership with other organisations. American studies have also demonstrated that where services in a city are well-integrated there is improved access to housing services (Rosenheek *et al,* 1999). British studies have also found that local homeless fora or joint working parties on homelessness can increase understanding of the needs and concerns of different services and initiate good practice on improving homeless people's access to services (Firth, 1998).

Nevertheless staff at the Fáiltiú Information and Advice Service reported that they had encountered difficulties with other agencies when trying to advocate on behalf of the clients. Warnes and Crane (2000) found that this

is due to homeless service providers' 'low standing in the traditional, professional and organisational hierarchies [which] reduces their ability to secure the co-operation of specialist services' (45). Other problems that arise include working with different management structures, overcoming suspicion, mistrust and hostility and addressing the resource constraints of each agency (Warnes and Crane, 2000). Furthermore, problems of confidentiality may arise and homeless service providers may be treated with prejudice and arrogance by other organisations (Warnes and Crane, 2000). When working in partnership, Stern *et al.* (2000) recommend that statutory agencies accept voluntary sector agencies as equal partners and the voluntary sector acknowledge the responsibility to work collectively rather than blaming statutory services when things fail to run smoothly (Stern *et al,* 2000). It has also been recommended that inviting health and social workers and housing executives to a day centre can establish good working relationships with complementary providers (Cooper, 1997; Warnes and Crane, 2000). This strategy would be welcomed by Fáiltiú staff members.

The HUB in Bristol[14] has achieved a national and international reputation for multi-agency working by uniting staff from voluntary and statutory and local and national organisations (Pannell and Parry, 1999). The service users have access to a 'one-stop-shop' with a full range of services under one roof (Pannell and Parry, 1999). The keys to the success of the project are:

- enthusiastic key players who support and promote joint working (especially senior managers);
- staff continuity;
- fora that are well co-ordinated and that effectively assess local need and develop plans for future service provision;
- the enlistment of key professionals from the private sector (such as the Chamber of Commerce);
- agreed aims, objectives and principles;
- the dismantling of tensions through joint training and placements;
- adequate resources, not only financial but also information resources and staff and 'political' support;
- and finally, equal balance of power between statutory and voluntary organisations. Pannell and Parry, 1999: see pages 246 - 258).

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[14] An advice centre for homeless people.

Conclusions and Recommendations

7.1 Conclusions

The service users in Fáiltiú are a heterogeneous group and are marginalised in a number of ways. They share a number of characteristics related to poverty and social exclusion such as poor educational qualifications, high levels of unemployment and experience of prison. The profile of service users shows that their needs are multi-dimensional and the Fáiltiú Information and Advice Service needs to respond to these needs in a holistic way. These needs include accommodation, financial support, social and personal support, medical support and access to employment and training services. This supports Giddens' (1984) theory of 'structuration' that solutions need to be offered at both structural and individual levels.

7.2 Recommendations

Recommendations have been advised that are acceptable to Fáiltiú's service users, practical for the staff and also effective within the budget constraints. According to Giddens (1984) established ways of doing things can be changed. The following recommendations seek a change in internal structures and external relationships. The ethos behind the recommendations is that information should meet the identified needs of service users and remain sensitive to their wishes.

Information Issues

- One-third of the clients who attend the Fáiltiú Resource Centre do not use the Information and Advice Service. Fáiltiú staff need to be more proactive in making these clients aware of the service, especially older clients who are significantly less likely to ask for help.

- Only a few of the clients reported accessing information through newspapers while no clients used television or the Internet for information. Therefore the Information and Advice Service should take the role of disseminating relevant information from these different sources, in a way that is appropriate to service users' needs and level of understanding.

- Half the clients of Failtiu had left school when they were 14, which could have resulted in literacy problems. Furthermore, service users pointed out than many of them could not read. The National Adult Literacy Agency (2000) recommends that information must be written in plain English, using everyday words. Therefore, in accordance with NALA, efforts should be made to distribute user-friendly information in Fáiltiú with a greater emphasis on visual information.

- To ensure that information is appropriate, homeless people should be involved in its design. As all of the service users were from Ireland and the UK there is no demand for information in other languages. However the need for this should be constantly monitored.

- Any information leaflets should be readily available and easily accessible for all service users.
- As 58% of the service users reported that they preferred to find out information by themselves, a touchscreen information database should be introduced in Fáiltiú on a pilot basis.
- Many of the clients received information and advice through their friends. This indicates that a peer support group, made up of 'opinion leaders', would be a useful information resource for service users. This group might also reach homeless people who avoid homeless services. A peer-led approach would make homeless people feel less patronised and more empowered.
- One of the difficulties in accessing information was the lack of rooms available to talk to staff. Consideration should be given to reviewing the space in Fáiltiú in order to maximise the amount of rooms for contact work.
- This study demonstrated the importance of recruiting an Information and Advice Officer for Fáiltiú.[15]

Role of the Information and Advice Officer

- The Information Officer should address gaps in information highlighted by service users, in such areas as housing, applying through the City Council, private rented accommodation, services for rough sleepers, emergency hostels, drug treatment and counselling services, health, aftercare, accessing deposits for flats, dealing with statutory agencies and organising workshops.
- The Information Officer should have a team of workers and ensure that they receive in-depth training in information and advice giving. The role of the team should be to ensure that all service users accessing Fáiltiú should have their basic information needs assessed.
- The Information Officer should work with other voluntary and statutory organisations to ensure that information given out is accurate and appropriate.
- Information should be shared with other agencies at the homeless forum and this platform should be used to establish stronger links with external agencies.

Staffing Issues

- The results showed that clients accessed a range of information in Fáiltiú. Therefore, it would be more effective if staff members specialised in providing information on different areas such as housing, social welfare, legal issues, health services etc.
- Fáiltiu' should consider introducing a professional key worker system on a needs basis, through systematic training and management support. If the service became more individualised this would show a willingness and ability to tailor services to meet a range of needs. This would help limit some of the difficulties mentioned by clients requesting information such as repeating their story to different staff members or having to queue to talk to staff.
- Advocacy needs to become an integral part of the key working system. This would involve staff representing clients when accessing accommodation, on legal issues or when trying to access different health services.
- Fáiltiu' staff need to continue participating in on-going training to tackle the problems and needs of homeless people, the role of key workers and developing listening and assessment skills. This training should provide staff with the ability to detect pronounced physical health needs and psychological problems, provide staff with a detailed understanding of the social welfare system and knowledge of emergency accommodation where clients can be referred.

Housing issues

The importance of good housing advice to help prevent homelessness has already been emphasised in other studies (Houghton and Hickey, 2000).

- 87% of service users were living in temporary housing. These clients need to be offered viable long-term housing options and given advice on applying for housing through the City Council.

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[15] Since this report was written an Information and Advice Officer was recruited in January 2003.

- In relation to the private rented sector, information is needed on accommodation that accepts social welfare payments, deposits for flats, payment of rent, rental arrears, legal obligations of the tenant and the legal obligation of the landlord.
- Information is also required on supported housing as many of the clients have led chaotic lifestyles and therefore require support to enable them to sustain a tenancy and live independently in the community.
- For rough sleepers there is a need for information on night shelters, soup runs, accessing sleeping bags and emergency hostels.
- 9 Furthermore there is a need for general housing legal advice on evictions and rent increases, advice on legislation such as the Housing Act, 1988 and anti-social legislation.

Support Issues

fhe results from the study indicate that information material is needed on a broad range of issues other than lousing.

- !. • Active involvement and co-operation by social housing and private sector landlords need to be encouraged.
- As half the service users were early school leavers and 53% had no formal qualifications, help is needed to link service users in with personal development courses and training and employment schemes.
- A substantial number of clients have been to prison highlighting the need for information on the criminal justice system and legal matters.
- Given that the primary cause of homelessness among Fáiltiú clients is family conflict, information on family mediation services for family conflict is essential.
- Information is needed on alcohol services and appropriate means of referral for the individual.
- t# Among those who were injecting drug users, 65% had Hepatitis C. This indicates that information is required on safe injecting, HIV and Hepatitis C. Information is also needed on drug treatment services. The staff at the Information and Advice Service should work closely with their colleagues in the Merchants Quay Drug Project to link clients into different services.
- The health status of the respondents was poor. Furthermore, almost half the clients had been in contact with A&E in the 3 months prior to interview. This is unsatisfactory as A&E are not geared up to addressing primary health care needs of clients. Therefore it is important that respondents are linked in with the primary health care centre at Fáiltiú when it is set up (in 2003).
- Less than half the clients have medical cards. These clients need to be targeted especially younger clients who are significantly less likely to have one.
- The levels of mental health complaints were extremely high among the service users. This implies that staff will need to recognise the signs of psychiatric problems and have the necessary information and skills to refer service users onto appropriate services.

.inks with other agencies

: is unrealistic to expect the Failtiú Information and Advice Service to meet the vast range of needs of its srvice users. Therefore the Fáiltiú Information and Advice Service should develop a more effective etwork of organisational contacts and stronger working relations with other voluntary and statutory rganisations.

- Failtiu needs to develop a closer relationship with housing services, including statutory services such as the Homeless Person's Unit, Dublin City Council and private landlords.
- It is also necessary to establish stronger links with medical, psychiatric, alcohol and drug services to facilitate referrals.
- The staff in Fáiltiu work with a significant number of ex-offenders and they therefore need to link in with probation services.

Government support

- There is a need for adequate government funding if these recommendations are to be achieved. There is therefore an obligation on the various funding bodies to play their part in the process of improving the standards of the Fáiltiú Information and Advice Service.

- The government needs to support inter-agency working as the results from this study have implications for health services, drug and alcohol treatment services, local authorities, and probation and welfare services.

- While this study specifically examined the development and improvement of the Fáiltiú Information and Advice Service, we should not lose sight of the wider issues that are of grave importance to our service users. There is a need for the government and the relevant statutory bodies to address the wider concerns of poverty and lack of affordable housing that have created and perpetuated the serious problem of homelessness in Ireland today.

Further Research

- Continual research needs to be carried out so that the Fáiltiú Information and Advice Service can develop and adapt to the changing needs of its service users.

- Further qualitative research should examine how homeless people view their world and describe it. This would help in the design of more appropriate information.

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