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Health of Hostel-Dwelling Men in Dublin

Perceived health status, lifestyle and health care utilisation of homeless men in south inner city Dublin hostels

Anne Feeney, Hannah M McGee, Tony Holohan & William Shannon

Department of General Practice &
Health Services Research Centre, Department of Psychology
Royal College of Surgeons In Ireland

&

Department of Public Health
Eastern Health Board

March 2000

Preface

Homelessness is an important and increasing social and public health challenge in Ireland. Among the primary concerns regarding homeless people is health. While there is concern about reduced life expectancy, increased morbidity and reduced quality of life in homeless groups, there has until recently been little specific evidence from which to develop policy or plan specific interventions.

The single term 'homeless' hides the reality of a very heterogeneous set of circumstances and subgroups of individuals. Focused information for service planning needs to be based on information from homogenous categories. This study examined the health status and perception of health service access of homeless hostel-dwelling men in Dublin since they constitute the largest single grouping of homeless Irish people as identified in previous studies[1,2]. The study was seen as part of an ongoing series of complementary projects which can inform best practice in healthcare delivery to homeless people. A previous brief 'health census' by Holohan[1] in 1998 formed the basis for this more detailed investigation of hostel-dwelling men. An equivalent study is currently ongoing by our team, with Health Research Board funding and in association with the Children's Centre, Trinity College Dublin, to consider women and their children in hostels and temporary rented accommodation in Dublin. A project to extend information from self-report to physical health examinations has been developed by the Eastern Health Board (EHB) and is nearing completion. The focus is on physical, mental and dental health examination. In parallel, qualitative research by the National Research Agency, on behalf of the EHB, is extending information on barriers to care and exposure to health risks.

The focus of the present study was examination of key findings from the 1998 health census in more detail. The topics addressed concentrated on lifestyle and behavioural risk factors; types and levels of physical and mental health problems; and health services accessibility, acceptability and use. The study was undertaken by a multidisciplinary team from the Royal College of Surgeons in Ireland (RCSI) and the EHB. The team's composition reflected concerns for the overall health of, and health policy required for, this group (Public Health); for behavioural risk factors, mental health problems and quality of life (Health Psychology); and for barriers of access to appropriate health services, particularly at Primary Care level (General Practice). This latter consideration of access was important in an evolving inner-city health service context where two of the three adult general hospitals, in the vicinity of both the men's hostels and the RCSI Department of General Practice, had recently closed. The project was based at the Department of General Practice, RCSI. Ms Anne Feeney, health psychologist, was the project researcher. The project was planned and managed by Professor William Shannon, Department of General Practice, RCSI (general practitioner and Professor of General Practice), Dr Tony Holohan, Department of Public Health, EHB (specialist registrar in Public Health Medicine) and Professor Hannah McGee, Health Services Research Centre, Department of Psychology, RCSI (health psychologist and Centre director). Dr Ruwani Siriwardena, formerly Lecturer in General Practice at the Department of General Practice, RCSI, was involved in the developmental phase of the project. The project was primarily funded by the Health Research Board with additional financial support from the Eastern Health Board.

The overall objective of this study was to provide new information about the health of homeless hostel-dwelling men in Dublin which will be of value in the planning and implementation of service plans for them in the new Eastern Regional Health Authority in the coming years.

Acknowledgements

We wish to extend our thanks to all respondents who gave of their time to participate in this research study and to the staff at the participating hostels who provided the support to make this project possible.

Sincere thanks go also to Ms Mary Higgins of the Homeless Initiative whose advice and assistance was invaluable in this study.

Mr Greg Maxwell and Mr Sean Megahy of Dublin Simon kindly provided advice and direction.

Special thanks go to research students Ms Caroline Corr and Ms Elizabeth Gilhooly whose diligent work on the project is greatly appreciated.

We wish to acknowledge the significant administrative contribution made to the project by Ms Monica Anne Brennan, Department of General Practice at the Royal College of Surgeons in Ireland.

We acknowledge the Centre for Health Promotion Studies, NUI Galway and Office of Population Censuses and Surveys (OPCS) for use of their research instruments.

We thank the Health Research Board for funding the project and the Eastern Health Board for providing top-up support

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EXECUTIVE SUMMARY

Background

Homelessness is a significant feature of today's urban settings in Ireland as elsewhere. Difficulties with health and healthcare access of homeless people is well documented internationally. Little has been known about the characteristics of homeless people in Ireland, including information on their health and health needs. Such information is necessary to effectively plan for this vulnerable group. A first brief 'on-the-street' study of health issues for a large group of homeless people in Dublin was completed in 1997. This study builds on this work and focuses on the status of the largest single grouping - homeless hostel-dwelling men in Dublin.

Methods

Men from the 3 south inner city men's hostels were interviewed about their health including physical symptoms, health status and presence of particular diseases; psychological distress; lifestyle and health care access and experience for the problems reported. A total of 171 men participated in interviews.

Results

This study found that hostel-dwelling men have unhealthy lifestyles including behaviours which increase risks of many common diseases. There is high utilisation of all medical services coupled with considerable unmet need in terms of treatment for specific health problem. The principal results are outlined in the following points:

Background information

- The majority of men who participated in the study were middle-aged.
- One-third of respondents had completed second level education.
- The majority of the men (59%) were single. If married, almost all (87%) were separated.
- Most of the men described themselves as homeless.
- 53% of men were homeless for more than one year.
- 15% of men reported being in care in childhood.

Lifestyle

- The prevalence of smoking was 84% compared with 32% of the general male population.
- 83% were regular drinkers compared to 81% of men from the general population.
- Almost two-thirds of regular drinkers exceeded the safe weekly limits and drank at hazardous or dangerous levels compared to 27% of men from the general population.
- 50% were alcohol dependent, with 29% having severe alcohol dependence.
- More than half of the men reported ever having misused drugs in their lives.
- Almost a quarter of respondents were categorised as having a drug problem.
- 12% reported that they had ever injected themselves with drugs.
- Fewer hostel-dwelling men engaged in moderate and strenuous exercise than members of the general population.

Health status

- 58% of the men perceived their health as good, very good or excellent while the remainder perceived their health as fair or poor.
- 91% reported suffering from at least one complaint. The average number of complaints for the group was three.

- Mental health problems were most common among this group, with 64% suffering from some form of mental health condition; 50% of respondents had a dental problem.
- While more than half of the men (52%) were suffering from depression, only one third of these men reported that they were receiving treatment for their condition.
- 54% were currently taking at least one form of prescribed medication.

Service utilisation

- 76% of men were registered with a GP in the Dublin area.
- 61% of men had been to a GP at least once in the previous 6 months.
- Of those having more than one visit, 91% returned to the same GP.
- 30% had been to A&E at least once in the previous 6 months.
- 28% had been to an outpatient clinic at least once in the previous 6 months.

Psychological well-being, social support and quality of life

- Using standardised assessment, levels of clinically significant psychological distress were very high; over four times the level of Irish men in the general population (at 53 vs 13%).
- Comparison with UK hostel-dwellers showed they were also 26% more likely to have levels of distress needing clinical intervention.
- One in four men reported they did not have a friend or family member they could call on for support if needed.
- Levels of quality of life were low; lower than those reported by a range of patient populations.

Conclusions

1. Hostel-dwelling men in this study were generally long-term homeless people for whom these hostels have become homes.
2. Many of the health problems identified were those resulting from, or contributed to, by lifestyle. Lifestyle risk behaviours were considerably greater among this group of homeless hostel-dwelling men than among the general Irish population.
3. Most of the health problems identified were common symptoms or illnesses. The prevalence of some of these problems was very high, in particular mental health and dental problems.
4. Alongside significant health problems, men reported low levels of social support and poor quality of life by community standards.
5. There was evidence of considerable unmet need in terms of treatment for specific health problems, particularly those relating to mental health.
6. There was high utilisation of all medical services (GP, A&E and out-patient services). These hostel-dwelling men did not appear to use A&E as an alternative to GP services, but rather were high users of both services.
7. Health care delivery through general practice was acceptable to these men. Where used it was associated with high satisfaction and high levels of return visits to the same practitioner.
8. Many men did not have a medical card despite entitlement. Not having a medical card was primarily related to lack of knowledge about the application process or about entitlements. It was not found to relate to administrative difficulties when attempting to apply for a card or to reluctance on the part of GPs to register homeless people in their practices.

Recommendations

1. Solutions and services for these problems should be focused on prevention, health promotion and primary care.
2. In order to reduce behavioural risk factors, a health promotion service for hostel-dwelling men is required which focuses on smoking, alcohol and drug misuse. This health promotion service should be integrated with the services which these homeless men use and should take account of the settings in which health promotion can take place, such as hostels. It should also include training for professionals within the primary care team to provide one-to-one health promotion as well as group activities.
3. The mental health needs of these homeless men require focused consideration including how, where and by whom such services can be effectively delivered to those most in need.
4. There is a need for education and support for health and related service professionals who deal with homeless men. This would allow an understanding of the specific problems experienced by homeless men to be developed, a reduction of barriers of access to services and the development of health promotion and disease prevention opportunities. There is a reciprocal need for education of staff in the voluntary sector around specific health issues for homeless men and the ways in which primary care for people who are homeless can best be accessed.
5. The proposed introduction of primary care teams with a remit concerning homelessness in the inner city (as outlined in the Eastern Health Board report entitled *Homelessness in the Eastern Health Board: Recommendations of a Multidisciplinary Group* (March 1999)) provides an important mechanism whereby the above recommendations can be realised. These teams should at all times act as a support to primary health care services to facilitate the re-introduction of homeless people into mainstream services. Action plans of these teams should be informed by the findings of the present study.
6. There is a need to develop links between GPs and other primary care professionals, health boards and voluntary agencies. The North and South Inner City GP Partnerships, the GP Unit and the Homeless Initiative are in a position to facilitate these links. This would help to integrate the provision of health services with the other services provided for homeless people, many of which, directly or indirectly, have an impact on health. The unique role of the agency TRUST, in the development of such partnerships to promote the health of homeless men, is acknowledged.
7. The medical card application process for homeless people should be more accessible. This should involve education of homeless men and staff with whom they have contact about entitlements and application procedures. Contacts with the health services should be used as opportunities to determine medical card status and to initiate the application process where appropriate.
8. Researchers, policy makers and service providers in this area should co-operate to ensure that the efforts of each are focused on the best use of resources in the interest of homeless people.

INTRODUCTION

Health is a basic requirement for independent living and is one of the core aspirations of individuals and nations alike. Many services are provided by the State on behalf of its citizens to promote and maintain health and to manage illness and disability in the population. These services are challenged to provide for people on the basis of need and in ways that are accessible and acceptable to users. In Ireland, the Government's health strategy document "Shaping a Healthier Future"[3] identifies equity as one of three underlying principles of their health strategy. Specifically, it identifies disadvantaged groups as requiring particular attention. Homeless individuals clearly constitute one such group.

The number of homeless people internationally has grown consistently since the 1980s.[4,5] Interest in and concern about homelessness has increased in recent years as evidenced by legislative change, funding for research and services and the emerging literature which has been published on the topic.[6-8]

4Approaches to defining homelessness

Homelessness is defined in many different ways. While some studies have described homelessness in vague terms[9] which do not allow for easy replication, comparison or generalisation of results, others have simply not defined homelessness.[10] The result is that programming and policy development have often proceeded based on varying assessments of the composition, size and needs of the homeless population.[11] Whether specific or vague, definitions of homelessness usually encompass duration (time) and location (place) of homelessness. The definition of homelessness in terms of these two variables reflects a conceptualisation of homelessness as a continuous variable that can be described by time and place co-ordinates.[11] Homelessness can, therefore, be located at some point along a spectrum of housing need with those without any formal shelter at one end and those who live in shared accommodation but have a clear preference to live separately at the other.[8,12,13] There is no agreement, however, about where upon this spectrum of housing need homelessness should be located and any attempt to place homelessness on this spectrum is necessarily arbitrary and potentially contentious.[8,14]

Legal definitions of homelessness

Homelessness has also been defined in legislation. In the UK, "legally defined" homeless people are often called the "official homeless". The legislation places responsibility on local authorities to help people who meet these criteria, provided they have some "local connection" to the authority's area of responsibility.[12] However, the UK official estimates of homelessness do not include rough sleepers, or those in hostels and bed and breakfasts. These are, therefore, often referred to as the "hidden homeless."[12]

Defining homelessness in Ireland

In Ireland, the Housing Act, 1988[15] sets out the legal definition of homeless persons to include those for whom no accommodation exists which they could be reasonably expected to use or those who could not be expected to remain in existing accommodation and are incapable (due to lack of resources) of providing suitable accommodation for themselves.

O'Sullivan has given due consideration to the issue of defining homelessness in an Irish context.[16] He recommends an approach to the definition of homelessness which takes adequate account of the legislative context and yet provides useful operational definitions for examining needs in this population. It sets out a continuum of homelessness which covers three broad categories (Figure 1.1).

Figure 1.1 Definitions of homelessness in Ireland[16]

Visible homeless	Shelterless	Sleeping on the street or in other places not intended for night-time accommodation or not providing safe protection from the elements.
	Homeless in shelters	Usual night-time residence is a public or private shelter, emergency lodging or such, providing protection from the elements but lacking the other characteristics of a home and/ or intended only for a short stay.
Hidden homeless	Housed but imminently shelterless	Temporarily lodged in provisional and uncertain arrangements that provide transitional accommodation only. Includes doubling up with friends/ relatives, illegally squatting etc.
	Housed but not in homes	In grossly inadequate accommodation, physically substandard and intolerable and which does not meet socially established norms for minimally decent housing.
At risk of homelessness		All those who currently have housing but are likely to become homeless because of economic difficulties, insecure tenure or relationship difficulties

Homelessness in Ireland

Under the Housing Act, 1988[15] local authorities are obliged to make periodic assessments of the level of homelessness in their area using guidance from the Department of the Environment. Four such assessments have been carried out between 1989 and 1996. However, these are generally regarded as an unreliable estimate of homelessness and have not been seen to have any practical impact on services to homeless people. Most homeless people in Ireland live in Dublin. O'Sullivan estimated numbers of homeless adults in Ireland at 2501 in 1996; 1776 (71%) of these were located in the Eastern Health Board region.[17] In 1997, Holohan conducted a survey over a 5-day period of the health status of homeless people in Dublin hostels, bed and breakfast institutions, food centres and on the streets. They identified 792 people of whom 510 (64%) participated in the survey.[1] However, the definition of homelessness which was used in that study was narrower than that used in previous estimates.

In an effort to achieve an accurate profile of homelessness in the Eastern Health Board area, the Homeless Initiative, in conjunction with the Economic and Social Research Institute and homeless service providers, carried out a survey of people who were homeless during the last week of March 1999.[2] People were defined as homeless if they were staying in a hostel, women's refuge, B&B, sleeping rough or staying with friends or family because they had nowhere else to stay. This definition of homelessness is consistent with those recommended by O'Sullivan.[16] The definition excluded asylum seekers. People were included in the survey if they came into contact with any homeless service or were on a local authority homeless list during the week. A unique identifier of initials, date of birth and gender was used to ensure no double counting. Information on duration of homelessness and family circumstances was collected.

The results of this assessment allow for the identification of unmet needs and indicate areas for further research. Such information is useful in itself but will become more so if it is collected consistently over time. It will then be possible to identify trends in homelessness, assess the effectiveness of services and the effect of policies and other forces on homelessness.

The survey found a total of 2,900 people in the area; 95% of them in Dublin city. There were two distinct groups, roughly equal in size. One group was on a local authority homeless list and did not use homeless services, the other used homeless services such as hostels and food centres. The local authority group tended to be women with children staying with friends or family. The service user group were generally single men, the majority of whom stayed in hostels. The survey found 275 people sleeping rough; one in five of them were under twenty years old. One hundred and sixty people were aged over sixty five and 420 people had been homeless for all of the last five years.

This assessment was not intended to provide a comprehensive picture of homelessness and the dynamic of homelessness. To do this would require intensive and extensive research on people who are actually homeless or at risk or potentially homeless. It did, however, provide a baseline of information against which comparisons can be made over time. Most importantly, it provided a definition of homelessness and a methodology for assessing it which has been agreed by those involved in service planning, funding and delivery. A broad message from comparison of the 1996 and 1999 Eastern Health Board survey data is that the problem of homelessness in the region is increasing significantly over time; there is for instance, in the short period of four years, a 63% increase in numbers of people recorded as being homeless.

Homelessness and health

Concern has been expressed about the lack of accurate information for health service planning in homeless populations and its dissemination between relevant agencies.[18] The circumstances of homelessness mean that many agencies cannot readily quantify or characterise the health status of homeless persons. Variability in the findings of many studies of health conducted among homeless groups can be accounted for by methodological differences.[19-22] Research is often limited by the lack of a comparison group to allow examination of disease among homeless people compared to housed people.[23-26] Many samples are prone to (understandable) selection bias and difficulties with generalisation to the larger homeless population not seen in that setting.[27,28]

It can be seen, therefore, that there are difficulties in the study of particular diseases or disabilities among the homeless. With these caveats, the available evidence on the health of homeless people, as it relates to the concerns of this study, is summarised next.

Lifestyle and behavioural risk factors

Homeless people are exposed to the same risks for physical illness as the general population but at higher levels, as well as to additional risk factors unique to homelessness.[29] Homelessness may impact on the health of individuals through several aspects of the homeless lifestyle.[19]

Some lifestyle issues among the homeless persons such as alcohol and substance abuse may contribute to or cause their health problems. While seen primarily as contributing to the risk of becoming homeless, alcohol or drug use may in some cases be a result of homelessness. Regarding avoiding or reducing health risks, the poor quality and transient nature of many of the settings in which homeless people live means that actions to maintain or improve their health are challenging to all concerned.[30] Furthermore, the disorganised lifestyle that accompanies most homelessness makes adherence to many health recommendations especially challenging.[31] How to avoid or quit smoking in living conditions where it is the norm, for instance.

Smoking

The reported prevalence of cigarette smoking among the homeless population has varied from 23%[36] to 78%.[37] The estimate based on Holohan's study of homeless adults in Dublin also found a prevalence of 78%.[1] The prevalence of smoking in the US has been found to be higher in homeless people when compared with poor housed people.[12]

Alcohol

Alcohol abuse has been cited as the single most prevalent health problem for homeless persons.[32] The estimated prevalence of alcohol abuse among homeless people has varied from 2% to 90% depending on the study design employed.[20] The highest rates seem to be among those drawn from shelters, streets and clinics.[33] Holohan's previous study in Dublin found that 29% of all respondents drank alcohol beyond recommended limits.[1, 34] Treatment of alcoholism in this group can be successful with studies showing improved physical and mental health and social stability.[35]

Drug misuse

Comparatively little has been written on the subject of homelessness and drug misuse, given the perceived prevalence of these problems in everyday practice.[38] The estimated prevalence of drug misuse among the homeless population has varied from 1% to 70%[20] while the earlier work has shown a lifetime prevalence of 29% among homeless adults in Dublin.[1] Among the homeless in the US, estimated prevalence rates are 10% - 15%[33] although one American study found a lifetime

prevalence of drug misuse among the homeless of 52.2%. It also estimated that the rate of current drug misuse among the homeless population was 8 times higher than the general population. [22]

Environmental conditions

The living conditions of homeless people; either on the streets exposed to trauma, weather and violence, or in hostels which may be overcrowded or have inadequate hygiene, along with factors such as smoking and lack of exercise, all contribute to morbidity and mortality.[28,39] Low temperature is an important cause of morbidity and mortality among the homeless.[28] Homeless people are exposed to the elements even if they are in temporary shelters because they must spend much of their day outdoors.[39] They are, therefore, at risk of sunburn, dehydration, frostbite and hypothermia.[19] Damp environments have also been shown to increase the incidence and severity of chronic respiratory problems.[40] The crowded living conditions of those who reside in shelters and the unsanitary living conditions of those who reside outdoors, may increase the risk of infectious diseases and infestations.[19]

Nutrition

Malnutrition is common among homeless people and may result from limited access to food, poor quality food, alcoholism, drug abuse or mental illness.[37,39] Various infections may be a complication of, or may be aggravated by, the nutritional status of the homeless person.[41] In many cities, inexpensive meals are available in hostels and day centres and free food is available from soup runs. In spite of this, homeless people still may not be eating well. They may lack the money needed to buy some meals, their irregular lifestyle may make planning of meals difficult and other problems such as alcohol and drug use can work against the maintenance of a healthy diet.[42] Finally, good nutrition may be almost impossible because of poor facilities for storing or cooking food.[43]

Health problems among the homeless

Health problems that are particularly associated with homelessness include tuberculosis, chronic obstructive airways disease, trauma, foot problems, infestation, epilepsy, peripheral vascular disease, severe mental illness and alcohol and drug misuse.[44-6] Their health problems also include common illnesses such as skin problems, functional limitations, seizures, social isolation, visual defects and grossly decayed teeth.[47]

The common medical problems of the homeless are magnified by their challenging living conditions.[45] The consequences of such diseases have been found to be greater among homeless adults and children, pointing to the role that homelessness plays as a risk factor for disease and disease complications.[48]

Chronic disease

Chronic conditions are much more prevalent among homeless populations.[8] Between 30% - 40% of homeless people report at least one specific chronic disease[49-51] while 80% to 85% of homeless people report that they have chronic health problems of some kind.[52,53]

The management of chronic disease compounded by homelessness is complex and frustrating. Standard textbook recommendations for the management of chronic disease may be unrealistic and impractical in the homeless population and the settings in which they live. The profound disorganisation of the homeless lifestyle militates against even minimal adherence to the simplest medication schedules.[33]

Infectious disease

Since the early part of this century, tuberculosis has been recognised as an important health problem in homeless settings.[59] The prevalence of positive tuberculin skin tests among homeless people is between 18% and 51%[60] while that of active tuberculosis disease is 1.0%[61] to 6.8%.[60] The latter rates are 150 to 300 times the US national average.[62] The positive skin test rate has been shown to increase progressively with the length of time persons spend in shelters or hostels. Unless successfully treated, many will go on to infect others in their families, institutions and the community at large.[45]

Scabies and lice infestation are common in homeless settings and can lead to secondary skin infections.[63] Despite successful treatment, re-infection is likely to occur because of the conditions in which homeless people have to live, e.g. cramped living quarters and the limited access to laundry facilities.[45,63]

Psychiatric disorders

Homeless people with mental health problems experience all the same difficulties that other homeless people meet but have more trouble meeting their needs because of their condition.[54] Those with psychiatric conditions are among the most studied sub-groups of the homeless population. Findings suggest that homeless adults may be more than twice as likely as the general population to have a psychiatric condition. Surveys of homeless people have estimated the prevalence of severe psychiatric disorder at 25%-50%[55-7] although estimates have ranged from 2% to 90% for mental health problems in general.[20] Functional psychoses have been most frequently reported while acute distress and personality disorder are also common.[58]

Health status and health care

Self-rated health and homelessness

Simple self-ratings of current and functional health status have been recommended to identify homeless people in poorest physical health.[37] Studies have found that 33% to 48% of homeless respondents rated their health as fair or poor compared with 18% to 21% of the general population.[21] In a study of older homeless men, only 18% of them perceived their health as poor, which was somewhat at odds with their recent hospitalisation rates and self-reported physical illnesses.[64] Those among the homeless who are most likely to perceive their health as poor include those with chronic illness, depression and alcoholism.[65] Others with poor perceived health among homeless population include women,[66] early school leavers and those who are long-term unemployed.[50]

Health promotion and disease prevention

Homeless adults require a range of preventive and routine medical services. Providing these services, however, can be challenging for practitioners. Homeless adults may be at risk of a variety of preventable diseases which are often overlooked because of their acute care needs.[67] It has been recommended that the approach to health promotion in the homeless should be multidisciplinary and should reflect both their health needs and their specific housing environments.[68] Simple preventive health plans could be based upon age, sex, risk factor profiles and conditions commonly encountered.[67]

Health service use

Primary care

General practitioners (GPs) hold the key to a range of primary health services[42] and registration with a GP can ensure that a homeless person receives the same quality of service as a housed person.[28] However, the evidence is that homeless people are more likely to use emergency departments rather than primary care facilities for both preventive and illness care.[69] High rates of GP service utilisation[1] and in-patient hospital utilisation[8] have been found amongst the homeless.

A study carried out in a primary care clinic setting based in homeless hostels found that the total number of annual consultations was similar to that expected from the general population but that the morbidity patterns seen were different.[27] Those who were in need of regular medication in the study, for example, were more likely to be registered with a GP.[70]

Accident and Emergency services

High utilisation of accident and emergency (A&E) services by homeless groups has been found.[71] The average number of visits per year among a population of homeless persons visiting an A&E department was seven. Alongside high services use however, a high level of dissatisfaction was also found.[71] The relatively high utilisation of A&E services of this group is thought to be due to a combination of higher morbidity and lack of access to primary health care.[71-3]

Hospital services

Homeless people are more likely to be hospitalised but less likely to use out-patient medical services than the general population.[74] Psychiatric illness is over-represented in the homeless population but mental health services are under-utilised in proportion to their needs.[75] Homeless people themselves relate their high rate of readmission to psychiatric hospitals to their lack of resources for survival and they point to the inability of the existing services to meet their own perceived and expressed needs.[76]

Self-reported health is an important predictor of utilisation of services by the homeless in the previous six months. Those reporting chronic medical problems are up to four times more likely to have used out-patient services and eight times more likely to have used in-patient facilities than those who report no medical problems.[52]

Barriers to utilisation of health services

General

Homeless people face many barriers to health care because of their housing status.[78] Figure 1.2. Barriers identified in accessing to health services[21,45,77] The major reasons that homeless people have difficulty in accessing health care can be summarised into three categories: problems with the health care system, the special and competing needs of homeless persons themselves, and the attitudes of health professionals.[77]

Figure 1.2 summarises the barriers encountered by homeless people in accessing health care.[21,45,77]

Health care system	Services unavailable
	Financial problems
	Organisational procedures and policies
	Manner of care delivery
	Appointment, treatment and follow-up arrangements
	Lack of outreach services
	Transportation difficulties
Homelessness and the homeless person	Competing priorities
	Fear of loss of control or financial loss
	Suspicion and fear of providers' actions
	Denial of health problems
	Personal feelings (related to attitudes of health care staff)
	Mental health and substance abuse problems
Attitudes of health care staff	General practitioners seen as unhelpful
	Insensitivity of service providers
	Prejudice and misconceptions
	Frustration at non-adherence to recommendations

These barriers of access to health care mean that homeless people often present late or not at all for health services.[39] Poor adherence to medical recommendations may also affect their ability to receive adequate and effective care.[19] However, the reasons for non-adherence are complex and may reflect an inability to recognise needs in themselves or barriers in access to medical services.[79]

Primary care and preventive services

It has been suggested that the problem in providing primary health services for homeless people lies not in the availability of services, but in their delivery. Some GPs may resist requests for registration with their practice from homeless people while some patients may be unwilling to share the same waiting facilities as homeless people.[24]

In the UK, while every citizen has a right to register with a GP, the processes are slow and GPs may be perceived as unhelpful. Reluctant GPs have been cited as the main reason why single homeless people have difficulties in getting access to health care. GPs themselves cite reasons such as the time factor, effects on the other patients in the practice and the "avalanche of need" that might occur should they begin to accept homeless people.[73] Homeless people may also have difficulty gaining

access to primary care because they remain on the list of the doctor from their home area.[72] Few incentives exist to encourage GPs to take homeless people onto their patient lists.[80]

Accident and Emergency and other hospital services

Homeless people have been found to be more frequent users of A&E services than others for both illness prevention and illness care.[69] They are also more likely to be hospitalised than the general population. Gatekeeping mechanisms designed to ration care may lead homeless adults to further avoid seeking hospital care in the early stages of illness if the care-seeking process becomes more arduous or time consuming.[29] A recent Canadian intervention found that explicit provision of compassionate care by staff in an A&E department reduced utilisation of that service by the homeless population in the area. There was higher satisfaction with the compassionate care service by homeless attenders.[71]

Health status and health care use of homeless people in Ireland

The first major study of health status and service use of the homeless in Dublin, was completed in 1997.[1] It comprised a brief (10 minute) interview of homeless adults by volunteer interviewers. Interviews were held in hostels, Bed & Breakfast (B&B) premises, food centres and on the streets. All but one Dublin centre permitted researchers to interview; 510 persons were interviewed - a 64% response rate of those invited to participate. Of those interviewed, 85% were men. Most were hostel dwellers (77%), with 6.4% sleeping rough.

The study recommended further research and identified areas for service development. The major findings from Holohan's study are described under Figure 1.3.

Figure 1.3 Summary of brief health census of 510 homeless people in Dublin 1998[1]

Health behaviour	▪ Almost 80% current smokers ▪ 30% consumed alcohol above recommended limits ▪ 30% took illicit drugs
Health status	▪ 43% reported being in poor health ▪ 66% had 1+ physical or psychological health problem (including common conditions such as diabetes mellitus, epilepsy & depression, as well as dental & foot problems) ▪ 41% had 1+ chronic cdsease ▪ 29% reported disimprovement in health in previous year
Health care use	▪ 55% had medical card ▪ GP attendance – 3.6 visits average in 6 months (those with medical cards); 1.8 visits (those without medical cards) ▪ Young men & street-dwellers particularly low medical card ownership ▪ Medical card possession not associated with presence of chronic disease ▪ Service use varied by age, gender, duration of homelessness and presence of chronic disease ▪ Street-dwellers used all services infrequently ▪ A&E services used for many illnesses which could be managed at primary care level ▪ Other barriers identified – language & cultural difficulties, information

Holohan's study provided an important first step in developing information on health needs of homeless people in Dublin.[1] Lack of privacy and time constrained in-depth investigation of topics with those interviewed in this first census-type study. The subsequent report from the Homeless Initiative[2] focused on documenting the size of the homeless problem and the pattern of homelessness. The Homeless Initiative report acknowledged the need for more information from

homeless people themselves on their routes into and patterns of homelessness and on their physical and psychological well-being and assessment of service provision for them. This is part of a logical progression in research with this group in Ireland, to consult with constituents about their experiences and aspirations as part of service planning. The study aims to build on the research findings to date to provide more focused information for service planning for this particular homeless population.

This Study

The population to be evaluated in this study is further specified as the 3 men's hostels on the south side of inner city Dublin (Iveagh Hostel, Back Lane and York Street). There are a number of reasons; pragmatic and representational, for this selection. Almost all (95%) of the homeless people in the recent Eastern Health Board 'census' live in the Dublin Corporation [city centre] area. A study of this group at this particular time is especially salient because of the changing hospital service profile in the area, i.e. two adult hospitals (Adelaide and Meath Hospitals) in the south side of the inner city had recently closed. The group was also of particular interest to the Department of General Practice, Royal College of Surgeons in Ireland since they provide General Medical Services (GMS) general practice services in the vicinity of the hostels. It is hoped that future local planning for homeless men, e.g. through inner city GP partnerships in the area, could be conducted with the assistance of study data.

Aim

To make evidence-based recommendations for optimal health care of homeless Irish men by documenting the health status and health care access of the largest single category of homeless people in Ireland - inner city Dublin hostel-dwelling homeless men:

Key questions for the study include the following:

a) what levels of physical and mental health problems are reported?
b) what treatment, if any, is availed of for the health problems reported?
c) what treatment is seen as appropriate for these problems by the men?
d) what difficulties, if any, have men experienced in availing of services?
e) what are their beliefs, experiences of applying for and uptake of medical cards?

Specific objectives

a) to document the physical and psychological well-being of these men;
b) to document their attitudes to and use of health services for their various problems;
c) to make comparisons of health and health care access between the homeless and other groups of people;
d) to identify barriers to effective management of the most serious health concerns of hostel-dwelling men; and
e) to develop local strategies for optimal management, in conjunction with relevant agencies, on the basis of the empirical evidence collected.

The project will contribute to a knowledge base on men's health more generally; a topic acknowledged as being relatively neglected by researchers and service providers to date.

METHODS

Study design

The sample consisted of adult men (men over the age of 18) who were homeless and living in one of the 3 hostels (N=316 beds) in the south inner city area of Dublin in 1999 (Iveagh Hostel, Back Lane and York Street). A homeless person was defined as someone who, at the time of the study, was resident in a hostel for the homeless and who were not resident in a psychiatric institution or 'houseless' by reason of ethnicity (i.e. travellers).

Potential participants were identified by contacting the relevant agencies with a protocol of the proposed study and receiving permission for the study to take place on their premises. Sampling times to invite men to take part in the study were varied to take into account the relative availability of men, for instance to ensure those out of the hostel during daytime would be adequately represented. In each hostel, notices were placed on public notice boards explaining the study. Individuals were approached by the researcher and asked if they would be willing to participate in the study. Confidentiality of the information collected, the voluntary nature of participation and independence of the research from the hostel were outlined. Potential participants were also told that interviews were expected to last about one hour and were offered £10, available on completion of interviews, as a token of appreciation for their participation. This procedure has been adopted in other studies to maximise response rates. Informed consent was obtained from those willing to participate. Participants were interviewed individually in separate rooms provided on site at each of the hostels.

Interviews were not undertaken where men were deemed to be under the influence of alcohol or drugs. Those identified as having serious psychiatric conditions or where there was a concern about violence, as determined by hostel staff, were not interviewed.

The interview

Some sections of the interview were conducted using questionnaires already standardised in the research literature. A brief outline of each of the sections of the questionnaire follows.

a) Demographic information

Basic information on topics such as age, marital status and education was recorded.

b) Details regarding homelessness

A brief description of the circumstances surrounding, and duration of, homelessness was sought. This was to develop further the information available from the Homeless Initiative study on routes into homelessness.

c) General health status and quality of life

Self-assessed health status was recorded by aspects of the SF-36[81] and general quality of life by the short-form Schedule for the Evaluation of Individual Quality of Life (SEIQoL).[82] The SF-36 (Short-Form-36 questions) assesses 8 aspects of health status by self-report; physical functioning, role limitation (physical), role limitations (social), social functioning, mental health, energy/vitality, pain and general health perception. Scores on each aspect are presented. Both measures can be compared with general population scores. SEIQoL assesses quality of life from the perspective of the person being interviewed. Thus individuals name the 5 areas most important to their quality of life, describe current functioning in each of these areas and outline the relative weighting or importance they give to each area in their judgement of quality of life. This information is combined into a single score from 0.0 – 100.0 with higher scores representing better quality of life.

d) Physical symptoms

Information was gathered on the presence of any chronic illnesses, and the use of prescribed medications. A 33-item physical symptom checklist[83] was used to record health complaints.

e) Use of health services
Participants were asked about their perceived health care needs, contact with health services and any difficulties or barriers they perceived in accessing health care in the previous 6 months. The interview combined question formats from the Irish Travellers Study,[84] the National Psychiatric Morbidity Survey of Great Britain,[85] Holohan's recent Dublin survey,[1] and Canadian[71] and Sheffield-based[86] research with homeless groups, in order to maximise the comparability of data and identification of common and unique features of the Dublin and other homeless populations. The topics covered were: medical card ownership; frequency of attending GP, A&E, outpatient and other health services in the previous 6 months; reasons for attending these services; satisfaction with most recent visit; attitude to aspects of the service; views on how the services could be improved to meet the needs of hostel dwelling men.

f) Lifestyle and health behaviours
Participants were asked about their levels of exercise and about smoking using the format of previous health surveys such as the *SLÁN Survey* [87] of health behaviours in the Irish public. This survey included N=6539 adults and was conducted in 1998.[85]

g) Alcohol and drug dependence
Questions on alcohol consumption were those used in the *SLÁN Survey.* [87] In addition, a 12-item measure of alcohol dependence was included which assessed loss of control, symptomatic behaviour and binge drinking. This measure was also used in the OPCS Survey of Psychiatric Morbidity Among Homeless People.[88]

Participants were asked about misuse of drugs including sedatives, tranquillisers, cannabis, amphetamines, cocaine, opiates, hallucinogens, ecstasy and solvents. These questions were drawn from the OPCS Survey.[88] The use of prescribed drugs was analysed separately. Lifetime use, current use and drug dependence were established for each drug. Obtaining information on drug misuse and alcohol dependence is difficult as respondents are likely to under-report these behaviours. In order to minimise this as a problem, participants were given the option of completing these sections of the questionnaire privately.

h) *Psychological status*
The 12-item General Health Questionnaire (GHQ-12) was used to provide a general measure of psychological distress.[89] Levels of caseness (% of participants who would be seen as needing help from a mental health professional based on the problems reported) can be identified with this measure. It is therefore possible to identify those who self-reported problems are sufficiently serious as to warrant mental health services. GHQ-12 has been validated in a study of over 5000 community participants as being as sensitive as longer measures in screening for psychiatric morbidity.[90] It has been used as the measure of distress for homeless participants in the recent first National Psychiatric Morbidity Survey of Great Britain.[85] Thus, possibilities for general population and other homeless group comparisons are available.

It was not possible in the present setting to have a clinical assessment of psychological status. Because of this, and because of self-selection of participants into the study, it is certainly the case that some serious and more psychotic types of psychological disorders would not be recorded here. Thus levels of psychological problems recorded in the study will necessarily underestimate prevalence in this group.

i) Social support available
The MOS Social Support Survey[95] was included in the schedule as a measure of four categories of social support. This measure assesses four dimensions of support: tangible support; affectionate support; emotional and informational support, and positive social interaction support. It also contains one structural support item which asks about the number of close relatives and friends available to provide support. Comparisons can be made with scores from a chronically ill adult sample.

Ethical considerations
In planning the study, a number of strategies were adopted to protect the well-being of the research participants and researcher and to protect confidentiality.

Well-being of participants
While all participants, by definition, were living in difficult personal circumstances, there may be occasions in studies such as this where the researcher perceives the individual to have serious acute difficulties - either psychological or physical. In these circumstances where it would be considered unethical not to act, the interviewer was in a position to provide appropriate assistance. For instance, in the circumstance of acute health care needs, details of emergency service access or general practitioner availability would be given.

Funds were allocated to pay for some counselling or general practice consultations should they be required. For other queries, an agreed contact name in an agency dealing with homelessness would be provided.

Well-being of researcher
A protocol to ensure interviewer safety was established. The researcher carried a mobile phone for security when travelling to and from hostels since they were inner-city based and since some visits took place during night-time or darkness hours. She interviewed participants in a room easily accessible by a member of security at the hostel, sat next to the door in interview rooms and notified hostel security when she was on the premises conducting interviews. Counselling services could also be paid for and availed of by the researcher if the intensive nature of the work created difficulties. It is important to emphasise that all of the above constitutes good research practice in otherwise unsupervised research settings rather than a fear of unique dangers in conducting research with homeless people.

Confidentiality of information
Completed interview forms did not have participant identifiers such as names. These forms were stored securely and no data identifying participants was stored electronically.

RESULTS

Population

Interviews were completed with 171 men from three inner city hostels. Response rates varied across the hostels; interviews were completed with three-quarters of the total number of men resident in Hostel A at any one time. The corresponding proportions for Hostels B and C are 52% and 33%, respectively. Participation in the study was voluntary, and fewer men in Hostel C were willing to participate than in Hostels A and B.

Demographic profile

The majority of men who participated in the study were middle-aged, with more than half falling in the 35-54 year age group (Table 3.1). One-third of respondents had completed second level education. The majority of the men identified themselves as single. Of the 70 who had married, 54 had either separated or were divorced from their wives, while eight were widowed. Eight men reported that they were still married to their wives. Eighty-five of the men had at least one child, with an average of three children. Family size ranged from one to 12 children (median = 2)[a]. Fifty-six men had a total of 121 children under the age of 18 years.

Table 3.1 Demographic profile of hostel-dwelling men, Dublin, 1999[†]

		N	%
Age	18-34 years	45	26
	35-54 years	91	53
	55+ years	35	21
Education	Primary school only	93	55
	Junior second level	26	15
	Completed second level	22	13
	Third level education	28	17
Marital status	Single	101	59
	Married	8	5
	Separated/divorced	54	32
	Widowed	8	4
Parenthood			
Men with children	1 child	23	27
	>1 child	62	73
Men with children under 18 years	1 child	25	45
	> 1 child	31	55

[†] All totals do not equal 171 due to missing data

[a] The median was used to describe the group as the data were positively skewed.

For the most part, participants in this study were Irish (Table 3.2). A small number were European Union (EU) citizens while the remainder were from countries outside the EU. Although 67 of the men have always lived in Ireland, a large proportion have lived outside of Ireland for some time (Table 3.2).

Table 3.2 Nationality and association with Ireland of hostel-dwelling men, Dublin, 1999

		N	%
Nationality	Irish	150	89
	British	15	9
	Other EU citizen	2	1
	Non-EU citizen	2	1
Irish association	Irish-born, always lived in Ireland	69	40
	Irish-born, lived abroad for some time	78	46
	Born outside of Ireland to Irish parents	14	8
	Other	10	6

Homelessness profile

In this study, it was of interest to see whether hostel-dwelling men regarded themselves as homeless. Men were first asked to describe their view of their current accommodation status. As outlined in Table 3.3, most of the group saw themselves as homeless with almost two thirds seeing this status as temporary or semi-permanant. Twenty-nine men reported that they were permanantly homeless.

Table 3.3 Self-defined accommodation status of hostel-dwelling men, Dublin, 1999

"Would you describe yourself as homeless?"		N	%
No:	I have a home here	5	3
Yes:	Temporarily	89	52
	Semi-permanently	20	12
	Permanently	29	17
Other		27	16

Duration of homelessness

For 103 of the men this was their first experience of homelessness. A substantial minority of these (n = 37; 36%) had been homeless for less than a year in total (Table 3.4).

Table 3.4 Duration of current episode of homelessness of hostel-dwelling men, Dublin, 1999

	Total sample		Men who were previously homeless		Men who were not previously homeless	
	N	%	N	%	N	%
Less than 6 months	56	33	33	50	23	22
6 months or more, less than 1 yr	23	14	9	13	14	13
1 yr or more, less than 5 yrs	59	35	14	21	45	44
5 yrs or more, less than 10 yrs	16	9	5	8	11	11
10 yrs or more	15	9	5	8	10	10
TOTAL	**169**	**100**	**66**	**100**	**103**	**100**

The median duration of the current episode of homelessness was 52 weeks.[b] Long-term homelessness was defined, for the purposes of further analysis in this study, as the current period of homelessness being of one year or longer in duration. Thus, 90 (53%) men were defined as long-term homeless.

Length of stay in current hostel

In this current period of homelessness, men had spent between one week and 45 years in the hostel where they were interviewed. On average, the men who had been homeless for less than a year had spent a median of five weeks in their current hostel, while the men who are identified as being long-term homeless had spent a median of 56 weeks in their current hostel (Table 3.5). Some of the men were recent arrivals: 38 men (22%) had spent less than a month in the hostel; 75 (44%) had spent between two and eleven months there and 8% (n = 14) had been there for five years or longer.

Table 3.5 Length of time in current hostel of hostel-dwelling men, Dublin, 1999

	Total sample		Short-term homeless		Long-term homeless	
	N	%	N	%	N	%
Less than 1 month	38	22	26	33	12	13
One month or more, less than 1 yr	75	44	53	67	23	26
1 yr or more, less than 5 yrs	44	26	-	-	43	48
5 yrs or more	14	8	-	-	12	13
TOTAL	**171**	**100**	**79**	**100**	**90**	**100**
(Median no. of weeks)	(24)		(5)		(56)	

[b]Mean = 182; range: 1 week to 45 years

Accommodation

In terms of previous accommodation, a range of options were used over the previous five years (Table 3.6). By definition, all men had stayed in a hostel at least once in the previous five years. Data from the Homeless Initiative study (1999) are also presented alongside. These identify which forms of accommodation were used by homeless men during a one week period. Direct comparisons are not possible due to the different methods of categorising the data in the two studies.

Table 3.6 Comparison of types of accommodation used by homeless men between this study and Homeless Initiative census, 1999

Hostel-dwelling men, Dublin, 1999 (N = 171)		**Homeless Initiative Census, 1999 (N = 1,850)**	
Accommodation types used in previous 5 years	**%**	**Accommodation type used in previous 7 nights**	**%**
Private rented housing	52	Hostel	61
Family home	29	Sleep rough	21
Friends	28	Friend (nowhere else to go)	9
Street	25	Other	4
Local Authority housing	16	Bed & Breakfast	3
Lived abroad	9	Own house/flat/other	1
Prison	8		
Health board provided	5		
Hospital	5		
Rehabilitation centre	4		
Squatted housing	2		
Other	5		

Reasons for becoming homeless

The reasons which respondents identified as resulting in homelessness are listed in Table 3.7. Although the men were able to identify one primary factor which led to their homelessness, for the majority the reasons for becoming homeless were complex. Family problems, combined with poverty and alcohol or drug misuse, resulted in many having "no place to go". Separation from wife or partner was the most frequently cited reason for homelessness. After leaving the family home, many men were not able to afford private rented accommodation. Problems with previous accommodation, cited by 29 men, included previous flats being destroyed by fire and no longer being able to afford increases in rent.

Table 3.7 Primary reason for originally becoming homeless reported by hostel -dwelling men, Dublin, 1999

Reason	N	%
Separation from wife or partner	31	18
Addiction problems	30	18
Problems with previous accommodation	29	17
Family problems	24	14
Unable to find work or accommodation after moving to Dublin	13	8
Health problems	12	8
Unemployment	9	5
Orphan	4	2
Other	16	10

Experience of being in care during childhood

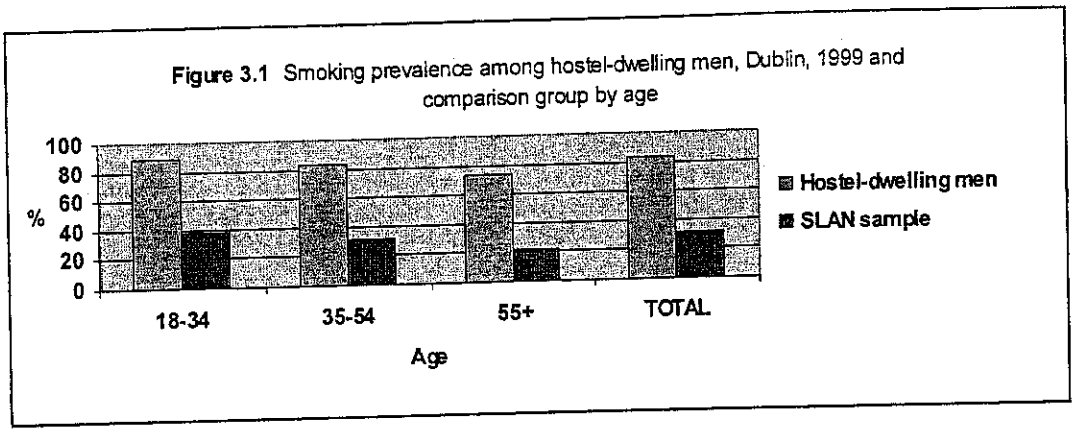
Early life experiences have been associated with vulnerability in adulthood, including vulnerability to homelessness[91]. Seven men reported childhood experiences as being directly responsible for their homeless situation. Fifteen percent of the men reported being in care in childhood. Fifteen had been in industrial schools or reformatories, seven spent time with extended family, six were in orphanages, one was in foster care and another in a special (learning disability) school. Almost half of these men were under 35 years of age, while a third were in the 35-54 year age category.

Lifestyle

Respondents were asked a number of questions on various aspects of their lifestyle, covering such topics as smoking behaviour, alcohol and drug use and level of exercise. Comparisons were made with Irish data from SLÁN, the National Health and Lifestyle Survey[87] and with UK data from The OPCS Survey of Psychiatric Morbidity Among Homeless People[88].

Smoking

The prevalence of smoking was 84% of respondents identifying themselves as regular (n = 141) or occasional (n = 2) smokers compared with 32% of the general male population[87] (Figure 3.1). There was no association between age or length of time homeless and smoking status for hostel dwellers although there is evidence that there is a reduced prevalence of smoking in older age in the general adult male population. The SLÁN survey reported prevalence rates of 38% among 18-34 year old men and 22% among 55 year olds and older.



The average number of cigarettes smoked daily was 31 (95% CI = 26.7 - 35.3)[c]. Thirty percent smoked less than 20 cigarettes daily, 38% smoked between 20 and 40 cigarettes a day and 31% smoked more than 40 cigarettes a day.

A small number of respondents had been regular smokers in the past but had now quit (n = 13; 8%). Of current smokers, efforts to or intentions to quit were low, as detailed in Table 3.8.

Table 3.8 Previous efforts and future intentions of current smokers to quit among hostel-dwelling men, Dublin, 1999

		N	%
"Have you ever tried to stop smoking?"	Never	39	28
	Yes, but not in past 2 years	59	42
	Yes, in past 2 years	41	30
"In the future, would you like to ..."	Carry on smoking	55	41
	Stop smoking in next 12 months	33	24
	Stop smoking at some point in the future	48	35

Alcohol Use

Regularity of consumption

Most of the group (n = 141; 83%) were categorised as regular drinkers. This is comparable to the figure of 81% of men from the general population[87]. [Regular drinking is defined by SLÁN as having consumed alcohol in the previous month.] Four respondents reported that they were non-drinkers. There was no association between age and length of time homeless and regularity of alcohol consumption (Figures 3.2 and 3.3).

[c] The confidence interval provides an estimate of the range in which the true population statistic can be expected to lie.

Figure 3.2 Regularity of alcohol consumption by age among hostel-dwelling men, Dublin, 1999

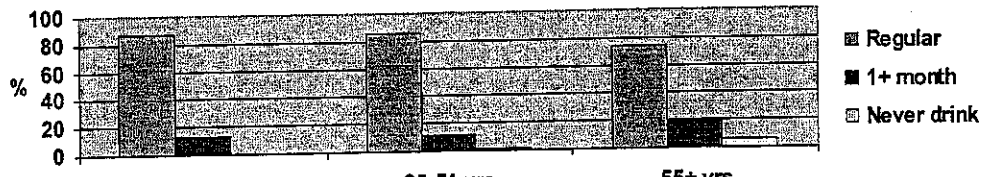
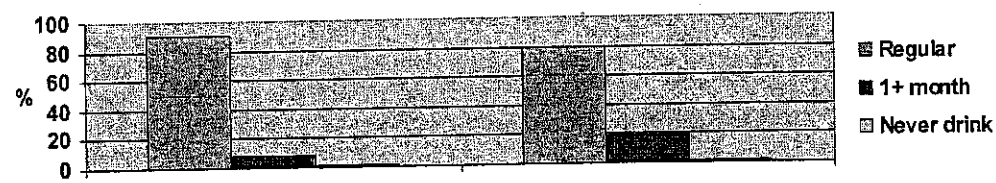


Figure 3.3 Regularity of alcohol consumption by length of time homeless among hostel-dwelling men, Dublin, 1999



Of those who had a drink in the last month, 82% reported that they typically consumed alcohol every week. Table 3.9 outlines this figure by number of days per week during which alcohol was normally consumed. One third of men reported that they drank alcohol on five or more days in the week. This compared with 14% of men who participated in the national survey. There was no relationship of age group or length of time homeless with the number of days per week during which alcohol was typically consumed. Twelve men could not say how many days they normally drink during the week, even though they reported generally consuming alcohol every week.

Table 3.9 Number of days drinking by regular drinkers in typical week by age and duration of homelessness among hostel-dwelling men, Dublin, 1999

	Hostel-dwelling men (N=102)			**SLÁN: male sample (N = 3,528)**		
	%			**%**		
	1-2 days	**3-4 days**	**5+**	**1-2 days**	**3-4 days**	**5+**
TOTAL	49	19	32	57	30	14
Age						
18-34 yrs	28	28	44	59	35	5
35-54 yrs	26	29	45	57	28	15
55+	33	11	56	52	23	26
Length of time homeless						
Short-term	38	24	38	-	-	-
Long-term	18	29	53	-	-	-

Category of alcohol consumption

According to the number of drinks consumed per week, 98 regular drinkers were categorised as safe, hazardous or dangerous drinkers. Sixteen men could not be included in this analysis as they had difficulty in answering how often they consumed alcohol and how many drinks they consumed per typical sitting. They reported drinking when they had the money and tended to drink at hazardous or dangerous levels when they did so. A small number of men (n = 6) reported no longer drinking but indicated that they had experienced problems with alcohol in the past.

A man was defined as drinking at a safe level if he consumed no more than 21 units of alcohol per week; hazardous drinking refers to consumption between 22 and 49 units of alcohol per week, and consumption of 50 units or more of alcohol per week was classified as dangerous. Almost two-thirds of regular drinkers exceeded the safe weekly limits and drank at hazardous or dangerous levels. This is greater than the national figure of 27% of men from the general population[87]. While there was no significant difference across the age groups on category of drinking (Figure 3.4), the proportion of men who drank at hazardous and dangerous levels was greater among the short-term homeless than long-term homeless men (Figure 3.5). These differences were statistically significant (RR = 1.4; $p < 0.01$)[d].

Figure 3.4 Category of drinking by age among hostel-dwelling men, Dublin, 1999

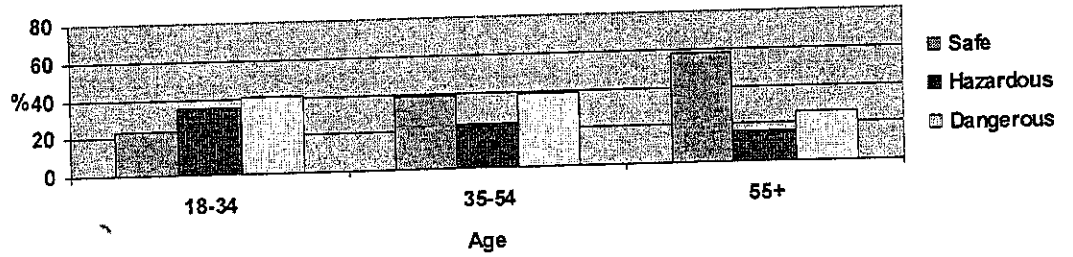
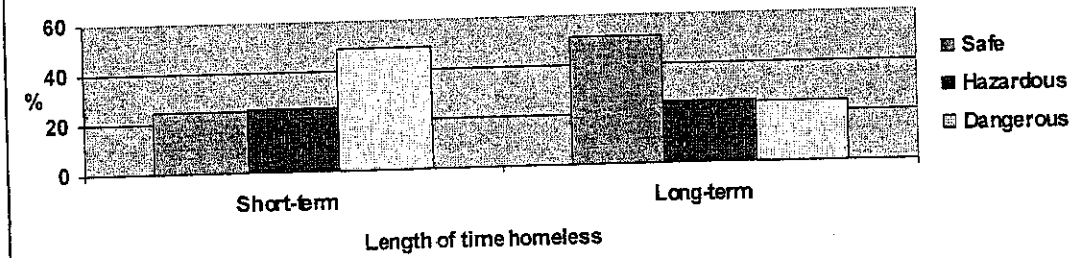


Figure 3.5 Category of drinking by length of time homeless among hostel-dwelling men, Dublin, 1999



Alcohol dependence

Alcohol dependence was assessed using the same 12-item scale from the OPCS[88] survey. Results are reported in Table 3.10. Fifty percent of hostel residents were defined as alcohol dependent, with 29% having severe alcohol dependence. These figures correspond to 16% and 10%, respectively, in the OPCS survey of hostel-dwelling homeless adults in the UK[88].

[d] Relative risk (RR) is the ratio of the risk of a particular event in one group to the risk in another group. It can be interpreted as a measure of how much more likely one group is to experience an event than another. For example, a relative risk of 1.42 means that men who were short-term homeless were 1.42 times more likely to exceed safe weekly recommended limits of alcohol than those who were long-term homeless.

Table 3.10 Prevalence of alcohol dependence among Dublin hostel-dwelling men, 1999 and British hostel-dwelling homeless adults

Scores	Dublin (%)	UK (%)
Alcohol dependance †	50	16
Severe alcohol dependance ‡	29	11

† Score of 3 or greater

‡ Score of 7 or greater

Younger hostel dwellers were significantly more likely ($\chi^2 = 8.7$; $p = 0.01$) to have severe alcohol dependency problems than older men (Figure 3.6), and those who were homeless for less than a year were significantly more likely (RR = 1.4; $p < 0.02$) to be dependent on alcohol compared with those who were homeless for a year or more (Figure 3.7). The latter finding was independent of age.

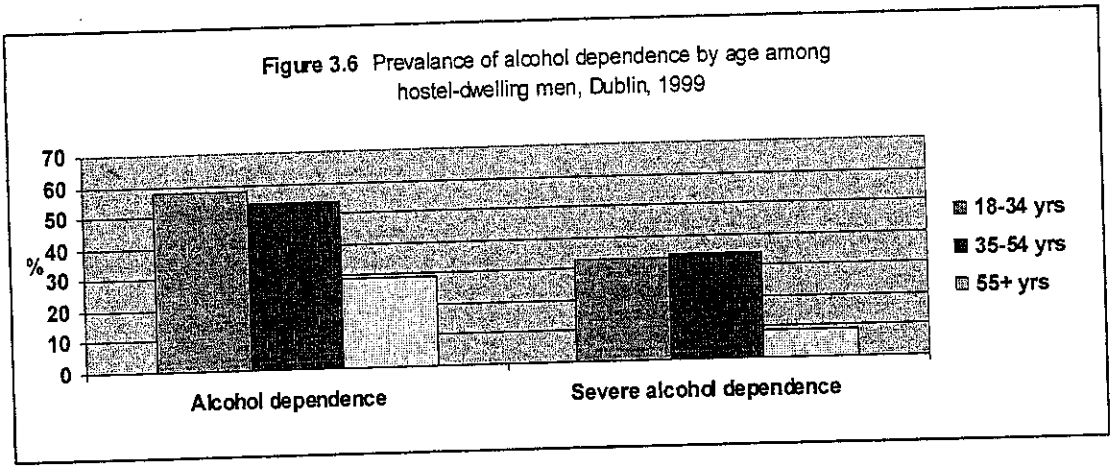


Figure 3.6 Prevalance of alcohol dependence by age among hostel-dwelling men, Dublin, 1999

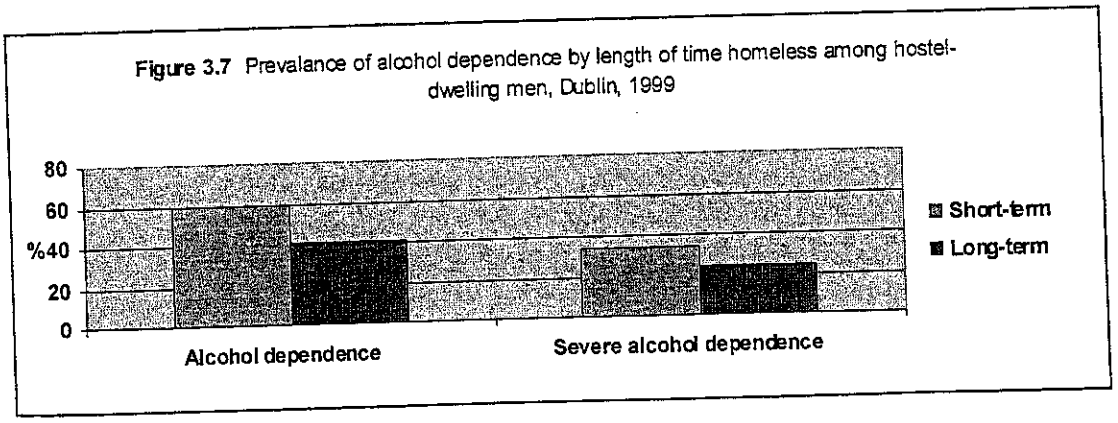


Figure 3.7 Prevalance of alcohol dependence by length of time homeless among hostel-dwelling men, Dublin, 1999

Drug misuse

Lifetime and current use

Respondents were asked to report on previous and current drug-taking behaviour. More than half of the men reported ever having misused drugs in their lives [e]. This compares with 26% of the male respondents in the OPCS study[88] . Older men were significantly less likely to have misused drugs than younger men (χ^2 = 39.1; df = 2; p < 0.001) while men who were homeless for one year or longer were less likely to have misused drugs than men who were homeless for less than a year (RR = 1.6; p = 0.001). These levels are presented in Figures 3.8 and 3.9.

Similar to the comparison group, the main drugs used by Dublin hostel-dwellers were cannabis (51%), psychedelics (28%) and amphetamines (24%). Lifetime use of other drugs ranged from 15% to 20% (Table 3.11).

Figure 3.8 History of drug use by age among hostel-dwelling men, Dublin, 1999

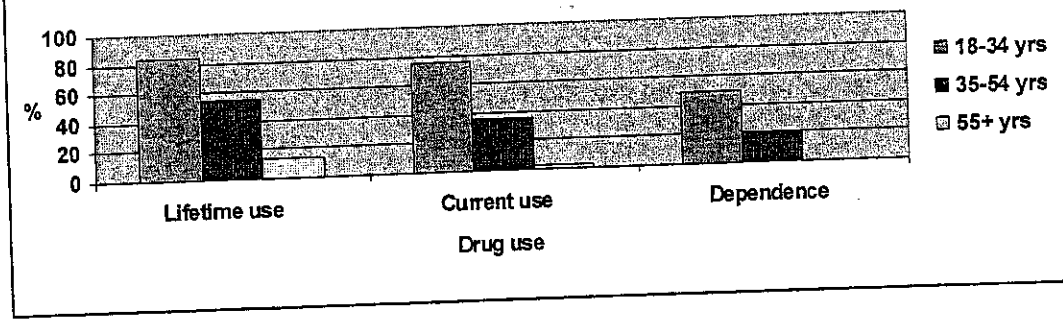
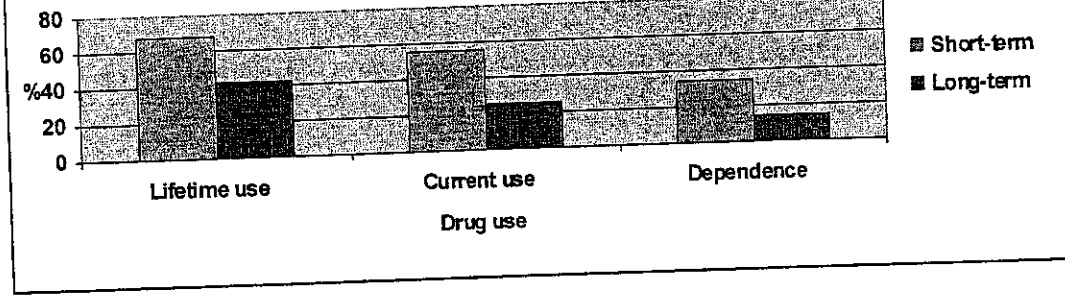


Figure 3.9 History of drug use by length of time homeless among hostel-dwelling men, Dublin, 1999



Current use was defined as use of a drug in the previous 12 months. More than one third of respondents reported having engaged in illicit use of at least one drug in the previous year. This compared with 7% among the comparison OPCS group. Younger men were more likely than older men to be current users of at least one drug (χ^2 = 44.4; df = 2; p < 0.01), while men who were homeless for one year or more were less likely to have used any drug in the previous year than men who had been homeless for less than a year. Cannabis was the main drug of choice with 30% of respondents categorised as current users; 14% took sleeping tablets and 12% took tranquillisers at some point in the previous year. The European Monitoring Centre for Drugs and Drug Addiction[92] reported figures ranging from one to nine percent for current use of cannabis in European countries.

[e] Statements regarding tranquillisers and sleeping tablets refer to illicit rather than illegal use.

Differences are also observed when the data is compared with that from the European Monitoring Centre for Drugs and Drug Addictions (1999). Rates of lifetime use are higher among the hostel dwelling men than national rates reported in the European study. For example, rates of lifetime use of cannabis ranged from 10% in Finland to 31% in Denmark. By comparison, 51% of hostel dwelling men reported using cannabis at least once in their lifetimes. Similarly, lifetime use of cocaine in European countries ranged between 1% and 3%, yet reached 20% in this sample of hostel dwelling men.

Drug dependence

According to criteria outlined in the OPCS study, respondents were classified as being dependent on a drug if they had taken it every day for two weeks or more in the previous 12 months[88]. Almost a quarter of respondents were categorised as having a drug problem, compared with 11% of hostel residents in the OPCS survey. Dependence was most common for cannabis, while 12 men were defined as dependent on tranquillisers and 11 were dependent on heroin. Dependence was more common among younger than older men ($\chi^2 = 27.7$; df = 2; $p < 0.001$) while men who were homeless for less than a year were more likely to have a drug problem than those who were defined as long-term homeless (RR = 0.5; p = 0.002).

Table 3.11 Illicit use of drugs by hostel-dwelling men, Dublin, 1999

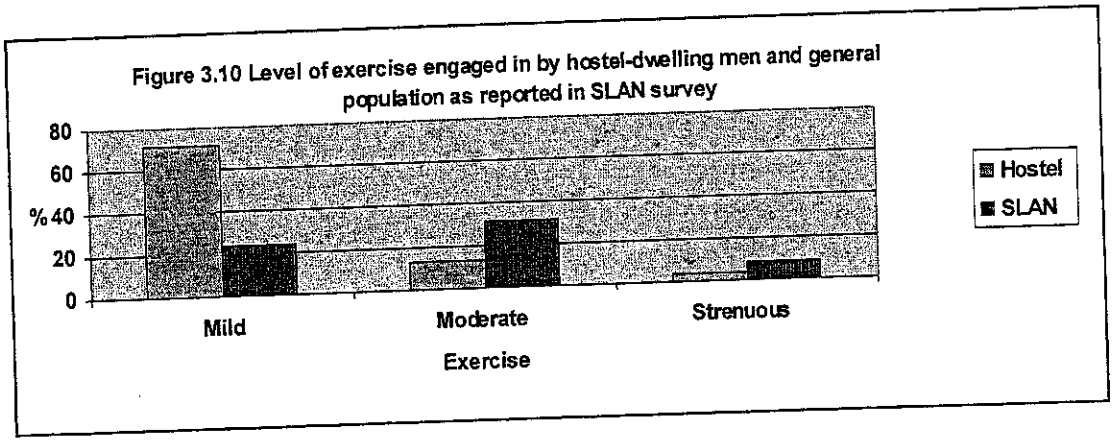
	Lifetime use		Current use		Dependence	
	N	%	N	%	N	%
Drug Type						
Cannabis	87	51	52	30	24	14
Psychedelics	48	28	6	4	2	1
Amphetamines	41	24	19	11	4	2
Ecstasy	34	20	15	9	4	2
Tranquillisers	34	20	21	12	12	7
Sleeping tablets	32	19	23	14	10	6
Cocaine	34	20	15	9	6	4
Heroin	30	18	18	11	11	6
Other opiates	25	15	7	4	4	2
Solvents	25	15	3	2	2	1

Of the total sample, 21 men (12%) reported that they had ever injected themselves with drugs (nine of 30 lifetime users of heroin had taken it without needles). Of these, 14 (8%) had shared needles in the past. In the previous month, eight men (5%) had injected and three (2%) had shared needles. These figures are higher than the corresponding figures from the OPCS study[88]. The UK study reported that 8% of respondents had injected themselves with drugs in the past, while 2% had shared injection equipment. Two percent had injected themselves in the previous month, and 1% had shared equipment.

Exercise

Respondents were asked the frequency with which they engaged in mild, moderate and strenuous exercise in a typical week. It was found that almost three quarters (74%) of the sample engaged in

some form of regular exercise on a weekly basis compared with 42% of the general population. Levels of regular physical exercise of hostel-dwelling men are compared with a national sample reported in SLÁN, the National Health and Lifestyle Survey[87]. Respondents reported greater frequency of mild physical exercise than moderate or strenuous exercise[f] (Figure 3.10). While this trend was also true of the general population, comparisons reveal that a higher proportion of the general population engaged in moderate and strenuous exercise than did the hostel-dwelling men (Table 3.12). One in eight respondents engaged in some form of moderate exercise on a weekly basis compared with a third of the general population. Likewise, fewer hostel-dwelling men (4%) reported engaging in strenuous exercise than members of the general population (9%). (Figure 3.10).



While younger men (18-34 yrs) were more likely to engage in strenuous exercise (RR = 2.2; $p < 0.05$) than middle-aged (35-54 yrs) men, no significant differences were observed for moderate exercise (Table 3.12). None of the men over the age of 55 years engaged in any form of moderate or strenuous exercise.

Table 3.12 Level of exercise engaged in by hostel-dwelling men, Dublin, 1999 and SLÁN comparison group.

	Hostel-dwelling men			SLÁN comparison group[†]		
	Exercise			Exercise		
	Mild	Moderate	Strenuous	Mild	Moderate	Strenuous
Age	%	%	%	%	%	%
18-34 yrs	71	20	11	33	34	20
35-54 yrs	68	14	2	21	27	6
55+ yrs	81	0	0	29	18	5

[†] The comparison group is made up of men from social classes 5 and 6 as SLÁN report presents data by age and social class

[f] Mild, moderate and strenuous exercise were defined according to the criteria applied by SLÁN.

General Health

Participants were asked about their health, including their perceptions of their health status, what conditions, if any, they were suffering from, and what medications they were taking at the time of the interview.

Twenty-five percent of the men perceived their health as excellent or very good, compared with 48% of SLÁN[87] survey respondents, while the remainder perceived their health as good, fair or poor.

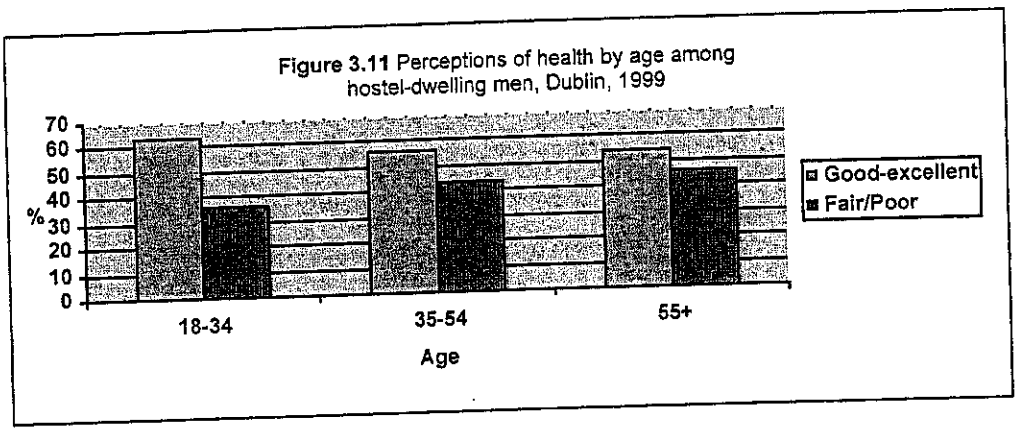


Figure 3.11 Perceptions of health by age among hostel-dwelling men, Dublin, 1999

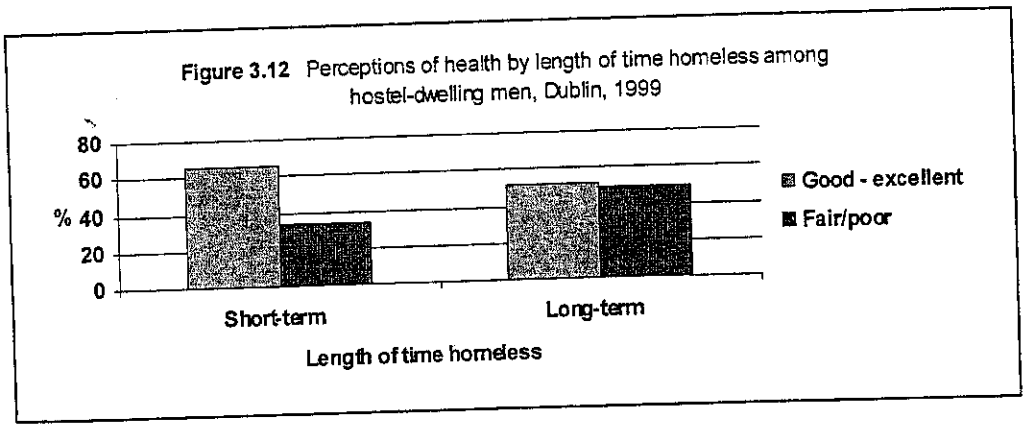


Figure 3.12 Perceptions of health by length of time homeless among hostel-dwelling men, Dublin, 1999

There was no statistical association of self-perceptions of health with age group or length of time homeless.

Health conditions

Respondents reported experiencing a number of conditions. These are listed in Table 3.13 in order of decreasing frequency. Conditions were grouped together into 4 main categories: mental health problems, chronic physical health problems, physical symptoms and dental health problems. The prevalence of these illness categories was not associated with age, length of time homeless or previous experience of homelessness. That is, these conditions were distributed equally across the various groups of men. Ninety-one percent of men reported experiencing at least one complaint. The average number of complaints for the group was three.

Table 3.13 Frequency of health complaints among hostel-dwelling men, Dublin, 1999

Category of illness	Condition	N	%
Mental health problem	**All**	**109**	**64**
	Depression	89	52
	Anxiety	85	50
	Other psychiatric problems	7	4
Physical symptom	**All**	**92**	**54**
	Eye and ear complaints	41	24
	Headache	36	22
	Problems with bones and joints	32	19
	Skin complaints	30	18
	Foot problems	26	15
Dental health problem	**All**	**85**	**50**
Chronic physical health problem	**All**	**95**	**56**
	Asthma	22	13
	Bronchitis/emphysema	22	13
	Peptic ulcer disease	17	10
	High blood pressure	17	10
	Heart disease	12	7
	Hepatitis C	8	5
	Rheumatic disease	7	4
	Epilepsy	6	4
	Gastro-intestinal tract	6	4
	Urinary tract	6	4
	Diabetes	4	2
	Tuberculosis	3	2
	HIV+	2	1
Other		**15**	**9**

Treatment

Although some of the health conditions were reported by a substantial proportion of respondents, many men also reported that they were not receiving treatment for these conditions. For instance,

while more than half the men reported suffering from depression, only one third of these reported that they were receiving treatment for their condition (Figure 3.13). When psychological distress was measured by the General Health Questionnaire (discussed more fully later), 72% of men scoring above the threshold of 3 were not in receipt of treatment for depression. Half of the men reported experiencing anxiety. Less than a quarter (22%) of these men were in receipt of treatment for this complaint at this time. The two illnesses which were most likely to be in receipt of treatment, if reported as present, were skin complaints and asthma.

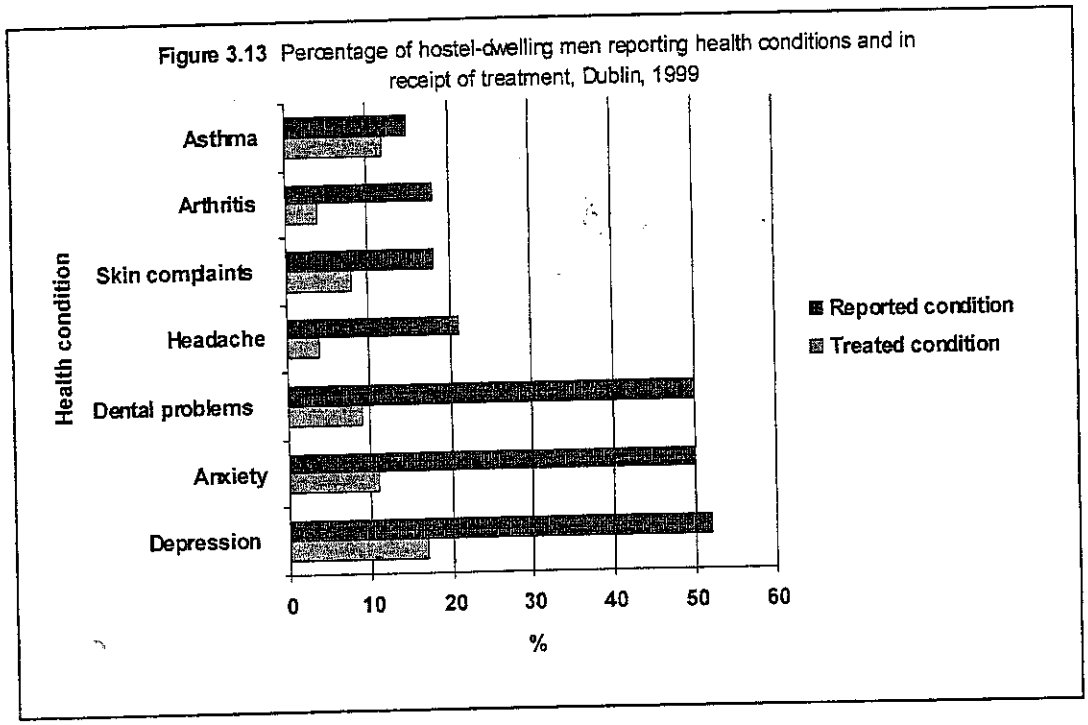


Table 3.14 outlines the percentage of men not receiving treatment for the various conditions by age and length of time homeless. For example, older men were more likely to be receiving treatment for depression than younger men ($\chi^2 = 6.9$; df = 2; p = 0.03), as were men who were experiencing their first episode of homelessness compared with those who had been homeless before (RR = 2.2; p = 0.01). There was no association of treatment by length of time homeless.

Even though there appears to be a trend for age and length of time homeless, where younger men and the long-term homeless are less likely to be receiving treatment than older men, and those who were short-term homeless, the differences do not reach statistical significance.

Table 3.14 Non-treated complaints by age and length of time homeless among hostel-dwelling men, Dublin 1999

	Age			Duration homeless		
	18-34 yrs	35-54 yrs	55+ yrs	Short-term	Long-term	TOTAL
Condition	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Depression	22 (88)	29 (58)	9 (64)	28 (60)	32 (76)	60 (67)
Anxiety	22 (96)	32 (70)	9 (70)	33 (79)	30 (75)	63 (74)
Dental problems	17 (81)	35 (81)	16 (76)	34 (76)	34 (90)	68 (82)
Headaches	11 (100)	16 (80)	1 (50)	12 (75)	16 (89)	28 (82)
Skin complaints	3 (38)	11 (65)	2 (40)	7 (58)	9 (50)	16 (53)
Arthritis	2 (100)	13 (81)	9 (69)	16 (76)	8 (80)	24 (77)
Asthma	5 (46)	0 (0)	0 (0)	3 (25)	2 (15)	5 (20)

Medication use

Ninety-two (54%) respondents reported that they were taking at least one form of prescribed medication at the time of interview. Older men were more likely to be taking prescribed medication than younger men ($\chi^2 = 7.5$; df = 2; p = 0.02) and those who were homeless for at least a year were more likely to be taking prescribed medication than those homeless for less than a year (RR = 1.5; p < 0.01). Taking medication was more common among men who reported experiencing mental health problems (RR = 2; p = 0.001), chronic health problems (RR = 2.4; p < 0.001) and physical symptoms (RR = 2.1; p< 0.001) than among those who had no experience of these problems.

Table 3.15 Medication use by age, length of time homeless and condition type among hostel-dwelling men, Dublin, 1999

		N	%
Age	18-34 yrs	17	38
	35-54 yrs	57	63
	55+ yrs	18	53
Length of time homeless	Short-term homeless	34	43
	Long-term homeless	58	64
Condition type	Mental health problems	69	64
	Chronic physical health problems	67	70
	Physical symptoms	64	71
	Dental health problems	49	50

Nine distinct categories of medication were identified. Frequency of use is outlined in Table 3.16. The mean number of drugs being taken by those hostel-dwelling men who were on prescribed medication was two, with a range from one to sixteen medications. Half were prescribed one or two medicines while almost one in five were taking three medications. Twenty men were prescribed four or more medications at the time of interview.

Table 3.16 Prevalence of use of prescribed medications by hostel-dwelling men, Dublin, 1999

Medication Type	N	%
Sleeping tablets	32	19
Tranquillisers	26	15
Respiratory system	22	13
Cardiovascular system	19	11
Antidepressants	17	10
Analgesics	15	9
Antipsychotics	14	8
Anti-side effects	10	6
Methadone	5	3
Other	35	21

Use of health services

Participants were asked what they would do in terms of seeking health care if they experienced a number of hypothetical illnesses or physical symptoms. These scenarios were selected by the research team to represent a range of problems which might result in options from 'wait and see' through 'self care' to use of emergency services such as A&E. They were given eight response options for each illness scenario. Table 3.17 outlines the responses for each of seven hypothetical health problems: toothache, foot problems, chest pain, back pain, rash, leg ulcer, and fatigue.

Table 3.17 Reported care options for hypothetical illness scenarios by hostel-dwelling men, Dublin, 1999

	Duration of condition	Nothing	Self-care	Consult hostel staff	Consult pharmacist	Consult GP	Go to A&E	Don't know	Other
		%	%	%	%	%	%	%	%
Toothache	24 hrs	15	15	1	2	3	3	2	60
Foot problems	24 hrs	21	20	1	4	30	8	6	10
Chest pain	24 hrs	9	3	1	0	59	23	2	3
Back pain	24 hrs	13	15	2	2	52	9	4	3
Rash	24 hrs	16	7	1	7	60	4	1	4
Leg ulcer	1 week	3	5	2	2	63	19	4	2
Tired	1 week	28	22	1	1	40	2	1	5

Respondents reported a pattern of consulting with more specialist service providers in potentially serious situations. For instance, 59% reported that they would visit their GP and 23% said they would attend A&E when asked what they would do if they experienced chest pain for 24 hours. By comparison, only 30% would attend a GP and 8% would attend A&E for foot problems which lasted 24 hours. While these were responses to hypothetical scenarios, these results do not support the stereotype of a primary and uniform reliance on A&E services for most health care by these men.

Medical card ownership

A significant minority of men (39%) did not hold an up-to-date GMS medical card[g] (Table 3.18). A number of reasons were given in explanation. Some men had cards which were out of date, or they were in the process of applying for a card or were about to apply for a card. However, 29 men claimed that they did not need a card while 6 reported that they could not get one because of their employment or pension status. Of the 61 men who did not have a medical card, 18 (30%) either

[g] A general medical services (GMS) medical card is a means tested entitlement to free access to medical care including medications and appliances. 25.2% of Dublin population currently hold a medical card.

believed that they were not eligible or did not know of their eligibility status for a medical card. One in five of these men did not know how to go about getting a card.

When asked about any difficulties encountered when applying for a medical card, there were virtually no problems with administrative aspects of getting the card. Furthermore, none of the men reported problems with having GPs take them onto their practice registers.

Table 3.18 Medical card ownership among hostel-dwelling men, Dublin, 1999

		N	%
Medical card ownership	Currently has card	104	61
	Card out of date	6	4
	"Don't need a card"	29	17
	"Can't get a card"	6	4
	In process of applying	14	8
	About to apply	8	4
	Other	4	2
	TOTAL	171	100
For those without medical cards:			
Do you think you are eligible for a medical card?	Yes	43	71
	No	13	21
	Don't know	5	8
	TOTAL	61	100
Do you know where to go to get a medical card?	Yes	47	80
	No	12	20
	TOTAL	59	100
All respondents:			
Did you have any difficulty in getting your medical card?	No trouble	107	63
	Haven't tried for one	40	24
	Difficulty in completing forms	1	1
	Difficulties with acceptance by GP	0	0
	Other	21	12
	TOTAL	169	100

Older men were more likely to have a medical card than younger men ($\chi^2 = 16.4$; df = 2; $p < 0.001$) as were the long-term homeless compared with the short-term homeless (RR = 2.1; $p < 0.001$). However, this was not independent of age.

Access to health services

In the six months prior to taking part in this study, almost three-quarters of the respondents had accessed the health services via GP, A&E services or outpatient services. The GP was the most commonly used health service with 61% of men having been to a GP at least once in the previous six months. Almost one third had been to A&E while 28% had been to an outpatient clinic (Table 3.19).

Table 3.19 Use of health services in previous 6 months by hostel-dwelling men, Dublin, 1999

	N	%
Any service	124	73
GP	103	61
A&E department	51	30
Outpatient department	47	28

The average number of visits were three to a GP, one to A&E and three to outpatient departments. There was no significant relationship between visiting any health service and age, length of time homeless or previous experience of homelessness. However, men were more likely to have had at least one visit to a GP if they also reported currently suffering from physical symptoms (RR = 1.6, p = 0.01) or if they reported a chronic physical illness (RR = 1.7; p = 0.004). There was no relationship between visiting a GP and reporting mental or dental health problems. Men who had attended an A&E department in the previous six months were more likely to be experiencing chronic physical health conditions (RR = 1.2; p = 0.04) while the men who attended outpatient services were more likely to report experiencing physical symptoms (RR = 1.4; p = 0.002) and chronic physical health problems (RR = 1.3; p = 0.01) than those who did not attend.

Access to general practitioners

Of the 103 men who had visited a GP in the previous six months, 69 reported more than one visit. The majority (91%) returned to the same GP for each visit, while four men (6%) visited two, and one man visited three different doctors.

Respondents were asked about their most recent visit to the GP. The most common reason for visiting a GP was because of an illness or requiring a repeat prescription. A small number of visits (7%) were categorised as 'administrative'; this refers to visits which were concerned with obtaining a medical card or seeking a letter to help with the individual's housing situation.

In general, men reported being satisfied with their most recent GP visits. Forty percent were extremely satisfied with, while 16% reported that they were either quite, or extremely dissatisfied with their most recent visit. By comparison, levels of satisfaction with GPs were at 74% in a study conducted in the Midland and Mid-Western Health Board areas[93].

A number of features of the service provided by GPs were rated with regard to potential barriers to accessing the service (Table 3.20). Structured features of service access were identified as the major problem with few complaints about aspects of service facilities or service quality in GP practices.

Table 3.20 Potential barriers to GP service use among hostel-dwelling men, Dublin, 1999.

Features of service		N	%
Service access	Not available at useful times	25	26
	Long waiting time	23	24
	Difficult to be seen by a doctor	15	16
	Difficult to get to	14	15
	Appointment system is difficult to use	12	13
Service quality	See a different doctor each visit	12	13
	Staff are not friendly	11	12
	Service is not user friendly	6	6
	There is a risk to my confidentiality	3	3
Service facilities	Waiting facilities are not adequate	6	6
	Other patients are intimidating	5	5

Respondents were also asked for their opinion on future provision of certain health-related services in the hostels (Table 3.21). They were generally positive about the possible provision of these services. The service which was endorsed least was provision of a mobile methadone dispensing service.

Table 3.21 Agreement with future provision of services in hostels by hostel-dwelling men, Dublin, 1999

Services	N	%
GP services	81	84
Chiropody services	79	82
Basic dental service	79	82
Nursing services	79	82
Transport to be provided to and from GP	71	74
Sick bay beds	70	74
Mobile methadone dispensing service	40	42

Access to Accident and Emergency services

Fifty-one men (30%) reported having attended A&E services in the previous six months. Of these, 19 (37%) reported two or more visits. The number of visits ranged from one to twenty. While the most common reason for the last visit to A&E was because of a physical illness (n = 41; 81%), two men reported attending because of feelings of anxiety or depression, while one man attended for a repeat prescription. Sixty-nine percent of A&E attenders had also visited a GP in the same time period compared with 57% of non-A&E attenders. These figures are not statistically significant. However, A&E attenders reported a greater frequency of visits to GPs than non-A&E attenders. Specifically, A&E attenders reported an average of 6.5 GP visits while non-A&E attenders reported an average of 2.6 visits. Most found their own way to the hospital (Table 3.22).

Table 3.22 Referral source to A&E among hostel-dwelling men, Dublin, 1999

	N	%
Self-referral	22	46
Hostel staff or gardaí called ambulance	10	20
Passer-by called ambulance	10	20
Friend called ambulance	5	10
Health professional called ambulance	2	4

Somewhat more men reported that they were satisfied than dissatisfied with their most recent encounter with A&E services (53% were extremely or quite satisfied, while 41% were quite or extremely dissatisfied). Features of A&E services were rated with regard to potential barriers to service access (Table 3.23).

Table 3.23 Potential barriers to A&E service use among hostel-dwelling men, Dublin, 1999

Features of service		N	%
Service access	Long waiting time	34	69
	Difficult to be seen by a doctor	31	63
	Difficult to get to	13	27
Service facilities	Other patients are intimidating	15	31
	Waiting facilities are not adequate	14	29
Service quality	Service is not user friendly	15	31
	Staff are not friendly	12	25
	There is a risk to my confidentiality	7	14

Access to hospital outpatient services

Forty-seven men (28%) reported that they attended outpatient department (OPD) services in the previous six months. Of these, 29 (62%) reported two or more visits. The number of visits to an outpatient department ranged from one to sixty.

Referral sources for the most recent OPD visit are documented in Table 3.24. The majority (69%) reported attending for a follow-up visit. This figure is in line with international recommendations that one new patient should be seen for every two returning patients at outpatient clinics, and is lower than the rate of 75% found in a recent study conducted in two other Dublin adult hospitals[94].

Table 3.24 Referral source to hospital outpatient departments among hostel-dwelling men, Dublin, 1999

Referral source	N	%
Follow-up visit	31	69
GP	6	13
A&E	4	10
Other hospital dept.	2	4
Other	2	4

There was a high level of satisfaction with the most recent visit to OPD; 82% reported being either extremely or quite satisfied, while 16% reported that they were either quite or extremely dissatisfied.

These men's opinions on a number of features of the service were rated and are outlined in Table 3.25.

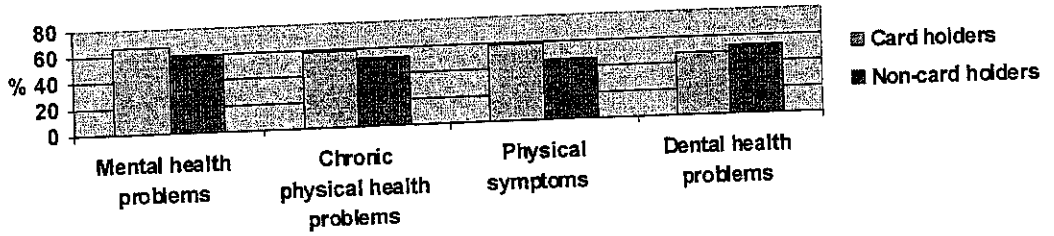
Table 3.25 Potential barriers to use of outpatient services among hostel-dwelling men, Dublin 1999

Features of service		N	%
Service access	Unlikely to be seen by doctor to whom referred	18	42
	Long waiting time	14	33
	Difficult to get to	10	23
	Long waiting time for appointment	7	17
	Not available at useful times	5	12
	Appointment system is difficult to use	5	12
Staff quality	Staff are not friendly	6	14
	Risk to my confidentiality	5	12
	Service is not user friendly		
Service facilities	Other patients are intimidating	5	12

Medical card ownership and general health

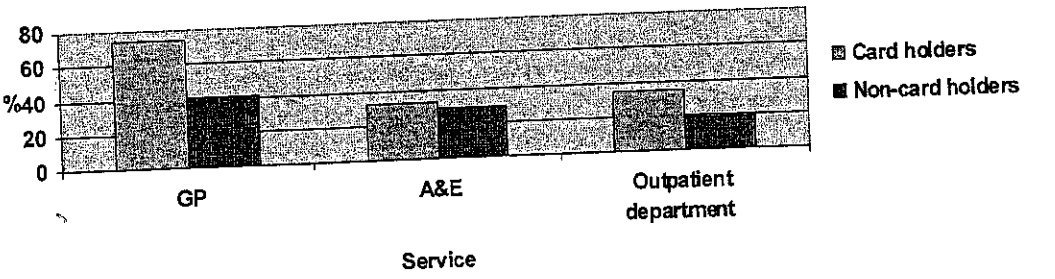
Medical-card holders were compared with non-holders according to reported illnesses and access to the health services. It was found that the four categories of conditions (mental health problems, chronic physical health problems, physical symptoms and dental health problems) were distributed equally across medical card holders and non-card holders (Figure 3.14).

Figure 3.14 Health conditions by medical card ownership among hostel-dwelling men, Dublin, 1999



However, card holders were significantly more likely than non-card holders to have visited a GP (RR = 2.3; $p < 0.001$) and an outpatient department (RR = 1.3; $p = 0.01$) in the previous six months. There was no difference between the groups in attendance at A&E (Figure 3.15).

Figure 3.15 Access to health services by medical card ownership among hostel-dwelling men, Dublin, 1999



Psychological well-being

Social support

Fifty-six men (37%) reported having no close friends and 69 (47%) men reported having no close relatives whom they could approach when they need support. One in four respondents reported having neither a close friend nor close relative for support.

Levels of social support on the MOS Social Support Scale appeared low when compared with a group of adult patients with chronic physical health problems[95]. While the full range of scores (0 - 100) was observed for the four categories of support measured, the highest mean score for any measure did not exceed 55.8 (Table 3.26). Hostel-dwelling men consistently scored lower than the comparison group of chronically ill patients on each of the four categories of support.

Table 3.26 Mean and standard deviation scores on categories of social support for hostel-dwelling men, Dublin, 1999 and chronically ill comparison group

Categories of support	Hostel-dwelling men (N = 161)		Comparison group (N = 2,987)	
	Mean	standard deviation	Mean	Standard deviation
Tangible	54.3	25.3	69.8	28.5
Affection	47.6	26.6	73.7	28.3
Positive interaction	55.8	24.5	69.8	26.0
Emotional/information	54.8	23.5	69.6	25.5

Psychological distress

More than half of the sample (53%) scored on or above the threshold score of 3 on the GHQ-12[89], a measure used to detect non-psychotic psychiatric disorder. This compares with 13% of men from the general Irish population in the Living in Ireland Survey.[96] Less than 39% of UK hostel-dwellers who participated in the OPCS study yielded a score of 4 or above. The equivalent figure in the current study was 49%.

There was no association with age even though the Living in Ireland study[96] reported that more adults in the 65+ age group experienced psychological distress than their younger counterparts. In fact, the trend among homeless men, although not significant, appears to go in the opposite direction with a greater proportion of younger men scoring at or above the threshold (Figure 3.16). Those who were homeless for a year or more were significantly more likely to be experiencing distress, as measured by the GHQ-12, than those who were homeless for less than a year (RR = 1.5; p = 0.01).

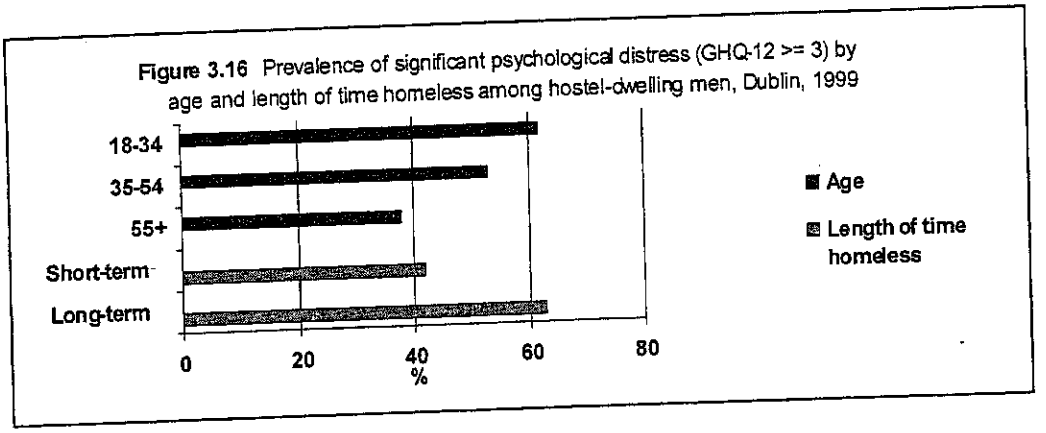


Figure 3.16 Prevalence of significant psychological distress (GHQ-12 >= 3) by age and length of time homeless among hostel-dwelling men, Dublin, 1999

Subjective health status

The subjective health status of the sample was measured by the SF-36.[81] Figure 3.17 summarises the distribution of respondent scores on the eight dimensions of the SF-36, along with the distribution of scores from a UK comparison group from which the norms for this scale were derived[97]. Scores ranged from 0 to 100 on all eight dimension, where 0 indicates poor health and 100 indicates good health. Hostel-dwellers scored lower than the comparison group on all dimensions.

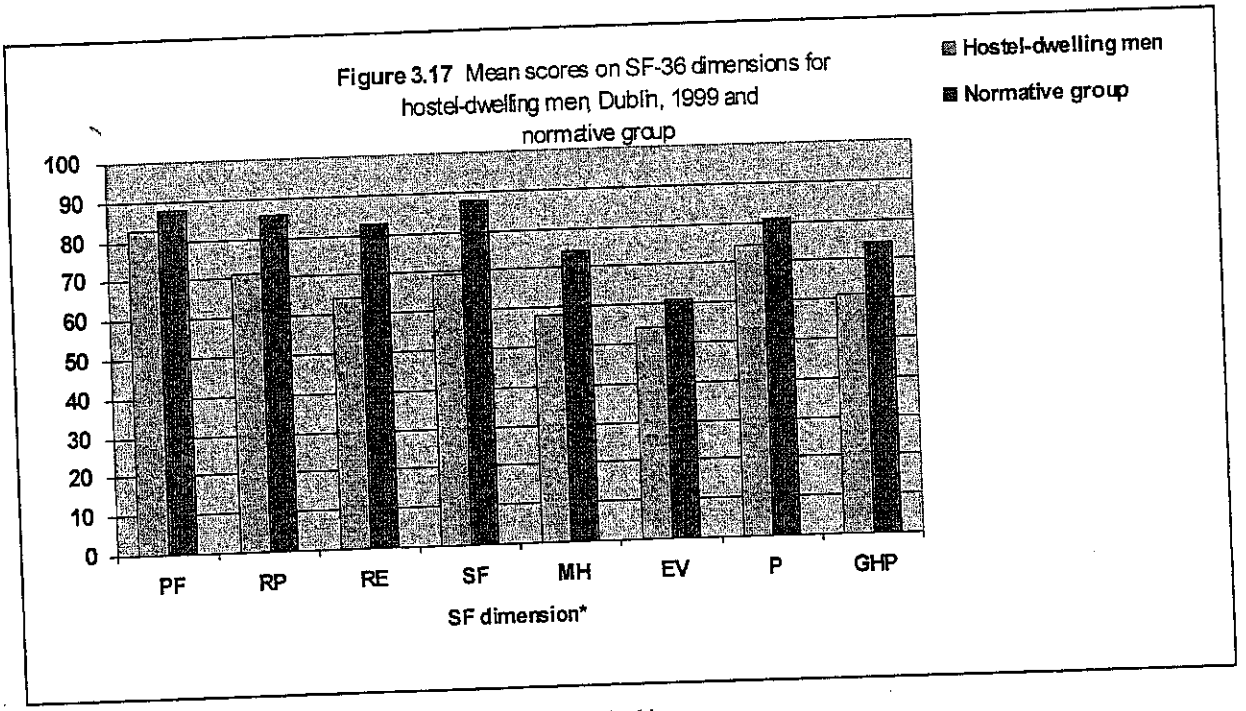


Figure 3.17 Mean scores on SF-36 dimensions for hostel-dwelling men, Dublin, 1999 and normative group

*PF: physical functioning
RP: role limitation due to physical problems
RE: role limitation due to emotional problems
SF: social functioning
MH: mental health
EV: energy/vitality
P: pain
GHP: general health perception

Scores on the SF-36 were related to age, length of time homeless, self-reported presence of health problems and medication use. Scores on two dimensions were related to age: younger men scored higher on physical functioning than older men ($\chi^2 = 6.6$; df = 2; $p < 0.05$), while older men yielded higher scores on mental health than younger men ($\chi^2 = 10.2$; df = 2; $p < 0.01$). Length of time homeless was related to scores on role limitations due to emotional problems: long-term homeless men scored higher on this dimension than short-term homeless men (RR = 1.37; p 0.05). Respondents who reported a chronic health condition or a physical symptom were significantly more likely to yield low scores on all dimensions except role limitations due to emotional problems. Respondents reporting a mental health condition were significantly more likely to yield low scores on all eight dimensions of the SF-36. Respondents who reported taking a prescribed medication were significantly more likely to report lower scores on all dimensions except on role limitations due to emotional problems.

Quality of life

Fifty-two (30%) men could not complete the structured quality of life instrument, the SEIQoL[82]. Of the remaining respondents, a large number of domains of life were identified as being important to their overall quality of life. Many of the selected were similar to those elicited by other groups, including healthy and chronically ill adult groups. The domains identified by the hostel-dwelling men are presented in Table 3.27 along with those nominated by a group of healthy attenders at an immunisation clinic[98].

Table 3.27 Areas of life nominated as most important to quality of life by hostel-dwelling men, Dublin, 1999 and by healthy attenders at an immunisation clinic

Areas of importance	Hostel-dwelling men (N = 119)	Attenders at clinic (N = 42)
Domains nominated by both groups	%	%
Family	63	62
Living conditions	63	21
Work	61	38
Health	57	83
Relationships	49	86
Social life	36	38
Finances	27	60
Independence	8	19
Religion	8	7
Happiness	2	48
Other	33	17
Domains nominated by hostel-dwelling men only		
Addictions	21	-
Security	2	-
Success	2	-

Family, living conditions, work and health were each cited by more than half of the respondents who completed this measure. Included in the 'other' category were areas such as ambitions and goals, sexuality and fulfilment. While there was considerable consensus as to the most important domains, there was variability in the relative importance attached to each category. For example, of the 75 men who rated family as one of the five most important areas in their lives, importance ranged from 10 to 70. Similar ranges were found for the other categories.

Scores on the SEIQoL ranged from 2.2 to 100. The mean score was 52.3, which represents the second lowest mean score yielded when compared with other populations (Table 3.28). For example, the mean score of a group of palliative care patients was 60.4, while a sample of healthy elderly had a mean score of 82.1. The only group with a lower mean was a group of patients with motor neurone disease. However, the difference between the hostel-dwelling men and the other groups did not reach statistical significance as such a wide range of scores are present within different groups.

Table 3.28 Mean scores on SEIQoL for hostel-dwelling men, Dublin, 1999 and comparison groups

Sample	n	Mean	SD	Range
Hostel-dwelling men	119	52.3	24.07	2.2 - 100
Healthy samples				
Healthy elderly	56	82.1	12.2	47.3 - 100
Young healthy adults	42	77.4	9.5	52.0 - 95.3
Healthy women eligible for HRT	64	76.5	12.4	7.0 - 96.0
Patient samples				
Peptic ulcer disease	28	72.6	10.7	25.8 - 95.4
Irritable bowel syndrome	28	62.8	10.9	50.9 - 93.6
Osteoarthritis	20	61.6	18.8	27.4 - 96.0
Palliative care	62	60.4	17.50	30.8 - 87.8
Motor neurone disease	8	42.9	27.4	2.0 - 78.1

To illustrate the variety of concerns and levels of quality of life of these men, profiles for three respondents are shown in figures 3.18 to 3.20. Although there was some overlap in the life domains nominated by all three as important to quality of life, there was considerable difference in overall quality of life scores. Figure 3.18 represents the quality of life of a middle-aged man, who was previously married, with older children. He reported experiencing depression and was rated as being extremely dependent on alcohol. He rated current level of functioning on all five important domains poorly; money, home life and work were particularly poor. His most important life domain (i.e. that given greatest weight) was family. His overall quality of life score was 9.6.

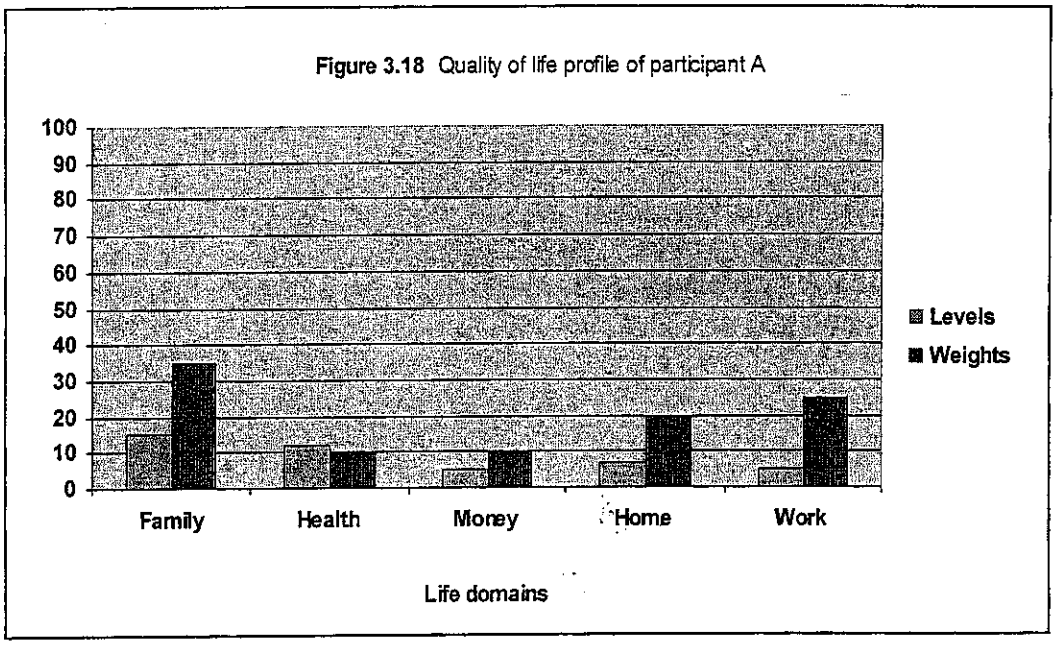
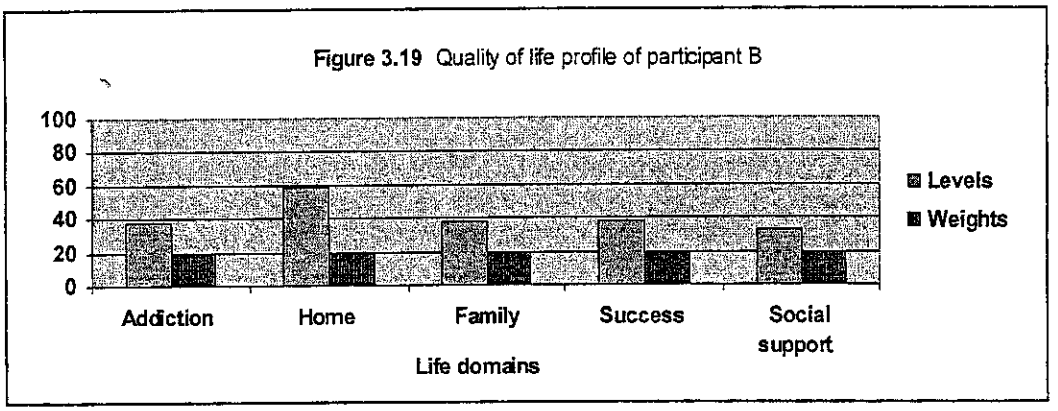
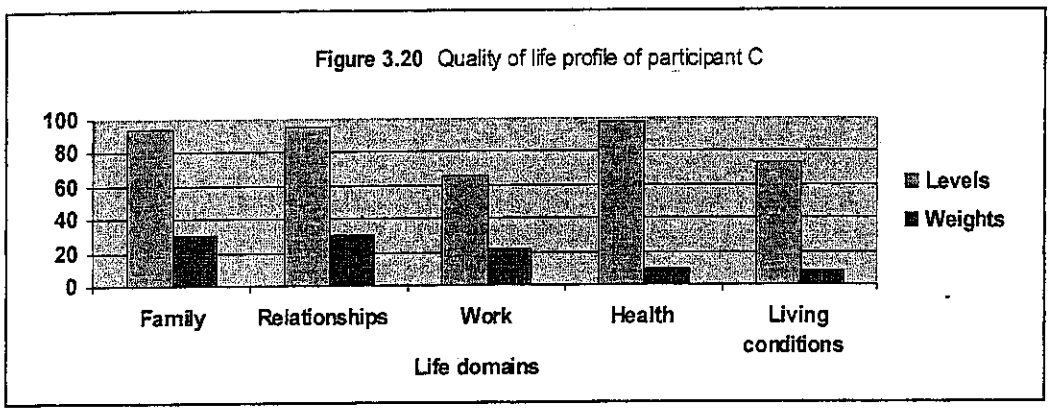


Figure 3.19 represents the quality of life of a heroin user who was categorised as long-term homeless. He rated current level of functioning in all but one domain in his life poorly, and assigned equal importance to each domain. His quality of life score was 41.0.



The quality of life of a middle-aged father is outlined in figure 3.20. He was separated from his wife. Current functioning on three of his important life domains was rated to be almost at best possible level while the other two were rated as functioning very well. He identified the most important life domains as his relationships with his daughter and girlfriend. His overall quality of life score was 86.8.



These profiles illustrate the wide variety of life concerns and of current life quality for this group of homeless men.

DISCUSSION

Introduction

The response rate achieved in this survey is in keeping with those achieved in earlier surveys of homeless men in Dublin. It is probable that the use of a stipend helped to boost participation given that the questionnaire took on average over one hour to complete. The proportion of respondents in each of the three hostels varied between one third and three quarters. It is not possible to outline the reasons why men did not take part, as there were few direct refusals to the interviewers. Instead, many of the men who did not take part simply did not make themselves available to be approached by the researcher.

Demographic details

The demographic profile of the homeless men in the three hostels included in the study was of a middle aged population of men who were mostly single or separated and had not achieved high levels of education. Nevertheless, the 171 men included in the study were fathers to over 250 children. This highlights the wider community impact of homelessness beyond the direct effects on homeless persons themselves. The low level of educational attainment in this group may be related to the reasons for homelessness for some individuals. It would certainly make it more difficult for some homeless men to get employment and re-establish themselves in society.

The fact that most men were separated or had never been married means that they may lack some of the usual social supports which would help them to re-establish independent living outside of a homeless persons' hostel. In the 1996 Census of Population,[99] 8.9% of ever-married persons in the Dublin County Borough[h] were registered as separated (including deserted and divorced persons). In this group of hostel-dwelling men, 87% of those ever-married (excluding those currently widowed) are separated. In fact, one in three (32%) of this group overall were separated men. This factor needs more detailed examination in a further study to ascertain what proportion of homelessness has marital breakdown as a primary cause and what proportion has both homelessness and marital breakdown as consequences of other difficulties.

While the majority of men interviewed were Irish, almost half of them had lived outside Ireland for some time. This appears to reflect travel abroad rather than birth elsewhere and relation to Ireland. Less than one in ten men who claimed to be Irish were born outside the country.

Homelessness profile

Men were first asked to describe their view of their current accommodation status. Most of those interviewed described themselves as homeless. The majority did not see their homelessness as being permanent. This was in spite of the fact that over half of all men interviewed had been homeless for periods in excess of one year and almost one in five were homeless for more than five years. Nevertheless, those who felt that they were permanently homeless or regarded the hostel as home had been homeless for much longer average periods than those who saw their status as temporary or semi-permanent. This implies that as the length of time one is homeless increases the greater the chance that one will regard their status as permanent. At this point it is less likely it will be that one would seek alternative solutions to their homelessness.

This assumes great significance when one considers that for the majority of men the current episode of homelessness is their first and in many of these episodes of homelessness have been of short duration. These men may be at risk of becoming institutionalised in hostels and should be prioritised for interventions which would support their early return to independent housing and living.

In terms of previous accommodation, this study and the Homeless Initiative census[2] jointly provide some new perspectives on accommodation use by homeless men. About half of the hostel-dwelling men had spent some time in private rented accommodation over the previous five years. A quarter

[h] This rate is the highest in the country; the national average is 5.4% with more women reporting separation than men

had experience of sleeping rough in those five years while one in five (21%) of nights of homeless men in the region were spent sleeping rough in the recent Homeless Initiative census. [2] Apart from private housing (whether with family, friends or self-funded), the major options availed of by these men were hostels or sleeping rough.

The reduction in the availability of low-cost accommodation in the private sector because of the growth in the Irish economy will inevitably increase the risk of homelessness for many people. Furthermore, many people appear to be only a "step away" from the streets. Over a quarter of men had shared with friends and family over the previous five year period in this study. In the Homeless Initiative report, 9% of nights of men in the past week were spent with friends "because they had nowhere else to go." [2]

Reasons for homelessness

Because of the time constraints and the health focus of this particular study, only the main reason for homelessness, as perceived by the men interviewed was queried. Such questioning is likely to identify the factors that precipitated homelessness rather than the underlying causes. The reason identified for homelessness are similar to those identified in homeless adults in Dublin in the past. Some underlying factors which could be assumed to play an important role in increasing the risk of homelessness did not emerge during the interviews. Being in care in childhood is a good example of this. Almost one in five men had experienced being in care during their childhood but few cited it as the main factor in determining their risk of becoming homeless. Other possible risk factors such as discharge from psychiatric and other hospitals, release from prison and mental illness did not emerge as prominent factors. This issue requires further detailed investigation using a variety of methodologies to inform strategies both to prevent homelessness and to target resources to managing the fundamental problems of those already homeless.

Lifestyle

Smoking

Previous finding of a very high smoking prevalence among homeless groups was replicated in this study. Smoking prevalence was high irrespective of age or duration of homelessness. The difference in prevalence of smoking between homeless men and the general population *SLÁN Survey*[87] emphasises clearly the greater health risks experienced by this group as a result of this preventable risk factor. It indicates the need for the development of smoking cessation programmes for homeless people.

The need for such smoking cessation programmes is further underlined by the findings that over half of all smokers would like to stop smoking and that nearly one third had tried unsuccessfully to stop in the past. However, a caution is that this level of interest in quitting is low when compared to a UK study of lifestyle and cardiovascular risk[100] which found a prevalence of smoking similar to Irish population patterns in a sample of over 5,000 adults aged 35-64 years surveyed by post from GP listings. High proportions wanted to quit and many reported seriously trying to quit in the previous 12 months. Smoking cessation supports such as one-to-one brief intervention counselling and smoking cessation clinics would help homeless men who smoke to quit and could thereby lead to a reduction in morbidity and mortality from smoking related diseases among them.

Alcohol Misuse

When considering alcohol consumption among these homeless men, they were no more likely to be regular drinkers than the general population. However, homeless men were more than twice as likely to consume alcohol more than five days per week and were more than twice as likely to consume alcohol beyond recommended limits than males in the general population in *SLÁN Survey*.[87]

A comparison of alcohol dependence between the participants in this study and those in the OPCS study of psychiatric morbidity among the hostel-dwelling homeless in Britain was made possible by using the same standardised scale. [88] In this study, alcohol dependence was more than three times as prevalent as in the UK while severe alcohol dependence was almost three times as prevalent. While it is possible that some of these differences could be explained by the fact that the Irish study did not include females, it is unlikely that the observed differences could be explained solely by this

factor. Alcohol misuse at this level among this population is a cause for concern and indicates an urgent need for preventive interventions appropriate to primary care and to the settings in which homeless men reside. The fact that younger and shorter term homeless men were more likely to report severe dependence should be reflected in the way in which the intervention programmes are targeted and delivered.

Drug misuse

Homeless people in this study were more than twice as likely to have ever misused drugs than those included in the OPCS survey in the UK. [88] The difference in drug misuse in the previous year was almost five times greater in Dublin. In spite of the differences in the prevalence of drug misuse, the types of drugs that are being misused appears to be similar in the two studies. As would be expected, the prevalences observed were significantly greater in younger than in older homeless people.

Almost 25% of homeless people in Dublin were classified as drug dependent using the OPCS criteria compared to 11% of those in the OPCS survey.[88] The lifetime prevalence of heroin use was 18% while that of heroin injecting was 12% compared to 8% in the UK. It is of concern that over two thirds of those in this study who had injected heroin in the past had shared needles compared to one quarter in the UK.

Exercise

It was found that 74% of participants engage in some form of regular exercise on a weekly basis compared with 42% of the general population. Levels of regular physical exercise of hostel-dwelling men were compared with a national sample reported in the *SLÁN Survey* [87] While it appears that more hostel-dwelling men than the general population are physically active, they were more likely to engaged in mild physical exercise while the general population engage in moderate and strenuous exercise. The difference can be explained by the fact that many homeless spend a number of hours each day walking around streets or parks and this results in them being allocated to the mild physical exercise category.

General health

Participants were asked a number of questions about their health, including their perceptions of their health status. When compared to the general male population in the *SLÁN Survey*, [87] they were less likely to rate their health as good/excellent (84% in the general male population versus 58% in the homeless male population).

The pattern of illnesses and health complaints that were identified was similar to those seen in a previous study of health in homeless people in Dublin[1]. Common psychiatric complaints such as depression and anxiety were prevalent as were many common chronic diseases which can be attributed to and exacerbated by the lifestyle and circumstances of homeless men. When the complaints were considered together as mental health problems, physical health problems, physical symptoms and dental health problems, they permeated age all groups of men irrespective of their duration of homelessness.

Treatment for specific health problems

Many men reported that they were not receiving treatment for the conditions which they experienced. While more than half of the men reported depression, only one third of these were receiving treatment for depression. When the General Health Questionnaire was used to identify those in psychological distress, more than half of the men above the threshold value of distress were not receiving treatment for either depression or anxiety. This indicates that there is a significant need for medical intervention for depressive illness, anxiety and psychological distress among the homeless, however this need is defined and that this need is not being met. As well as indicating inadequate access to appropriate treatment, it is likely that this unmet need increases the risk of suicide in this vulnerable population and reduces their ability to successfully reintegrate into society.

This pattern of high unmet need in terms of receipt of treatment for specific health complaints was seen with each health problem for which it was examined. It varied from very high levels of unmet need in the case of dental problems to lower levels in the case of asthma. It would appear from the types of illness for which unmet need is greatest that more acutely distressing illnesses such as asthma and complaints such as skin problems are more likely to receive attention. This may be because the provision of treatment is based on the initiation of help seeking by the person themselves. If this is the case, it argues strongly for the provision of a service which can reduce impediments to consultation as much as possible and which can provide an outreach component which is designed to identify and respond to unmet need.

Medication use

More than half of the participants were taking at least one prescription medication and, as would be expected, older men were more likely to be taking medication. Medication use was greater among those who complained of specific physical or mental symptoms. This indicates that self-reported need is associated with a greater likelihood of using prescription medication.

A comparison was made between the types of medication used by respondents in this study and the population with medical cards. Direct comparison was difficult as the categories used do not correspond fully with one another in that the GMS data shows the percentage of the scheme which is accounted for by a given class of medications. This study gives the number of respondents using a particular class of medications. It suggests that homeless people may be more likely to be users of psychiatric, respiratory and analgesic medication than the general population but lower users of medications for cardiovascular disease.

Table 4.1 Medication use among homeless men compared with the GMS population (1998) [101]

Homeless men			GMS population (1998)
Medication type	**N**	**%**	**% of scheme**
Psychiatric	53	21.0	13.1
Respiratory	22	13.0	9.9
Methadone	5	3.0	-
Cardiovascular	19	11.0	19.8
Analgesic	15	9.0	6.6

Use of health services

Respondents indicated that they would be likely to consult with a GP for problems which could be regarded as serious. In the case of potentially less serious problems, the preference tended to be for doing nothing or dealing with problems themselves. Homeless men, therefore, in terms of their intentions to use services, appear to chose solutions and care settings appropriate to the problem concerning them.

When help seeking behaviour in the previous six months was considered, some consistency with the findings in relation to intention to use services emerges. GPs are more commonly and frequently used than A&E services. This appears to conflict with the stereotypical view that homeless men preferentially seek care in A&E departments rather than in more appropriate settings. Furthermore, those who have used A&E services in the previous 6 months were not less likely to use GP services. This also argues against the view that A&E services are being use as a substitute for GP services. The likely explanation is that high users of one service were high users of all services. This is supported by the finding that those who had visited A&E in the last six months had a higher mean number of GP visits in the same time period than those who had not. The high use of A&E services in the previous six months indicated a high level of need for episodic care which might be more appropriately catered for in primary care.

Access to general practitioners

The pattern of visitation and high levels of repeat visitation to GPs suggests that good continuity of care was afforded to those who use GP services. This is borne out by the fact that satisfaction with GP services was high. Nevertheless, almost one in six respondents reported extreme dissatisfaction with GP services. The most common difficulties reported by participants were that the GP was not available at useful times and that waiting times were too long. These factors could be expected to reduce access to GPs as well as a range of other primary care services. Strategies to improve access for homeless people to GPs could lead to a reduction in A&E visitation rates.

Multidisciplinary primary care teams with a remit around homelessness should be introduced in the inner city. The teams should be small, multidisciplinary and integrated with the other primary care services provided within the city centre. The teams should aim to improve the health and social well-being of the homeless through the provision of integrated care which links people into mainstream service.

The objectives of the primary care teams should be to:

meet primary health care needs for homeless people who do not currently have adequate access to primary health care services

support the linking of homeless people back to mainstream services

support mainstream primary care in its efforts to provide registration and services for homeless people

link homeless people into secondary and other services where appropriate

liase closely with other professionals in the inner city in relation to provision of health and social services

The precise composition of the team and the respective roles of each of the members of the team should be considered in some detail prior to their establishment. One of the members of the team should act as co-ordinator for the team in all of its functions. This person would be the named contact for the team for the purpose of referrals and would direct the delivery of appropriate services for those in need. The team should have the input of nurses, doctors, social workers, community welfare officers, care attendants, community psychiatric nurses, outreach drugs workers and administrators.

Access to Accident and Emergency services

Almost one third of men had visited A&E in the last six months although in the majority of cases this was for a single visit. The reasons for which people attended A&E included seeking help for problems such as depression, anxiety and chronic physical symptoms which could be dealt with more appropriately in another setting. When the sources of referral were examined, less than one in twenty were made by other health professionals. The majority were self referrals or referrals by hostel staff, Gardai and others. The presence of acceptable, accessible alternatives to A&E attendance which was publicised to the homeless, the hostels, Gardai and others could help to reduce the burden of referrals to A&E services of homeless people. It would also appear that A&E services are less acceptable to homeless men than GP services. Common difficulties experienced include long waiting times, difficulty in being seen by a doctor and the intimidating nature of A&E services. This further underlines the need to develop alternatives to A&E for homeless people.

Access to hospital outpatient services

Over one quarter of men had visited a hospital out-patient department in the previous six months. In over two thirds of cases, these men were attending for repeat appointments. Less than one in six had received a referral by a GP in the previous six months and a similar proportion had been referred there from other hospital departments. While satisfaction with these services was high participants highlighted some difficulties which included being unlikely to be seen by the doctor to whom they were referred, the long waiting time and difficulty in getting there.

The high numbers attending these services, particularly for repeat visits, suggests that some homeless men attending hospital outpatients could be more appropriately cared for in the community. The presence of a primary care team which could link closely with inner city hospital based services could help to reduce reliance on out-patient services for repeat visitation. It could provide a service which a hospital service could refer to, share care with and consult to ensure that a homeless person is cared for by an acceptable and integrated primary care team in the community.

The provision of certain health-related services in the hostels was considered acceeptable to participants in this study. The service which was endorsed least was provision of a mobile methadone dispensing service. The services which were included in the questions in this study were based on services which have been provided to homeless people in hostel settings in other countries. This study has established that the introduction of such services as part of the development of services in Dublin would be acceptable to hostel residents.

Medical card ownership

Examination of medical card ownership among participants included an enquiry about reasons why participants did not hold a medical card. It is important to note that unwillingness to take homeless people on to their lists on the part of GPs did not emerge as a reason in any of the cases. The most common reasons for lack of a medical card can be attributed to lack of knowledge about eligibility or about how to get a medical card. It should be possible to include in the remit of a primary health care team working with the homelessness, a responsibility for education of hostel staff and homeless people about the medical card application process as well as a responsibility to identify individuals without cards who could then be helped through the application process. This would be a simple yet effective way of ensuring progress towards equity of access to primary care services by homeless people.

Reporting ill health, as defined by the presence on one or more specific complaints, was not associated with an increase in the likelihood of possessing a medical card. In spite of this, those with a medical card were heavier users of GP services. This indicates that there is inequitable access for equal need among homeless people resulting from the distribution of medical cards among them.

Psychological well-being

Social support

This study found that about one in four men had no close friend or relative to whom they could turn for support if needed. This finding parallels earlier demographic evidence on the high levels of marital breakdown in the group. Of interest, when compared with a chronic illness group, they differed most in their lower level of access to affection (of four types of support: affection, tangible support, positive interactions and emotional support). The absence of such support may be a cause, contributing factor or consequence of homelessness. It is beyond the scope of this study to determine the relationships. Whatever the relationship of support and homelessness for these men to date, their reintegration into society, including housing, will depend to a significant extent on being able to assist them to rebuild or replace systems of social support in their lives.

Psychological distress

Levels of clinically significant psychological distress were alarmingly high in this group with more than one in two men reporting clinical levels of distress. They were over four times more likely than Irish men in general to report such high levels of distress. Even in the context of homelessness, they were 26% more likely than UK hostel-dwellers to report such serious levels of distress. While the stereotype of homelessness includes the view that those with serious psychological problems are more likely to end up in this predicament, it is not clear when homelessness follows mental health problems and vice versa. The challenges of homelessness; for instance loss of control over most aspects of life, threats to personal safety, shame or rejection by family or friends, are profound challenges for even the most psychologically robust person to deal with and still maintain equilibrium.

In this setting, the challenge to restore a more regular existence, including stable personal accommodation, is likely to be virtually impossible when men have also to contend with serious mental health problems. Outreach services may be particularly necessary to address mental health problems in this group for a number of reasons: firstly men in general are less willing to seek help for mental health problems than women; secondly Irish mental health services are currently very over-streached and efforts to seek help which meet with waiting lists and appointments into the future are likely to detract from service uptake; and finally coping strategies to deal with mental health problems (such as alcohol and illicit drug use) are likely to have subsequent detrimental effects on physical health, personal safety and tenure of hostel-dwelling status for these men. The even higher levels of distress of younger men, and of those long-term homeless, identify groups at possible risk of serious consequences including suicide.

As cautioned earlier, this study can only reflect levels of self-reported distress. Where more serious mental health disturbances and psychotic behaviour are concerned, other research strategies are needed to evaluate the extent of these difficulties. Whatever the mechanism of action, there is a clear need for health planners to address the mental health needs of this group.

Using this as a measure of the presence or absence of depression showed moderate agreement with self-reports of depression among the homeless. This indicates that it may be a valid tool to identify those who self-report depression. Using the threshold score for the GHQ as an index of need for intervention for depression, the likelihood of using antidepressant medications was no greater than in those below the threshold score.

Subjective health status and quality of life

The unfavourable self-rated health status as demonstrated in this study, even when compared with a group of people with pre-existing illness, indicates the high level of need in this population. Similarly, the poor quality of life of the group, when compared with populations experiencing serious illness, reflects the difficulties of this relatively young group of men. What is notable is that most of their important life concerns are about family, work and health – just like their general population counterparts. It is instructive to keep such core similarities in mind while planning for these men as a distinct and separate group in terms of health service planning.

Overview

This study aimed to expand current knowledge on the health and healthcare needs of Dublin hostel-dwelling men. The project was undertaken at a time when the numbers of people becoming homeless were increasing significantly and when local and international factors were influencing this development. For instance, the 'Celtic Tiger' has meant escalating costs for accommodation and a parallel shortage in available accommodation because of demand through increased job opportunities in cities like Dublin.

The project is one of many necessary pieces of information necessary to inform ongoing planning and service delivery to homeless groups. As specified earlier, other projects involving women and children or incorporating physical health examinations are currently underway. Two types of project are particularly needed for the future. Action research projects are needed to evaluate the relative efficacy of different methods of service delivery, for instance what methods of delivering mental health services for those in need are most acceptable to those men already homeless. Such projects focus on the best means to promote health and independent living for these men. Research projects which seek to understand the causes of homelessness, and most importantly the factors which either trigger homelessness or maintain independent living when people are at risk of homelessness, are also needed if the future is to be oriented towards prevention rather than management. From this study, the role of marital breakdown, drug misuse and serious mental health problems appear most worthy of more detailed evaluation.

Conclusions

1. Hostel-dwelling men in this study were generally long-term homeless people for whom these hostels have become homes.
2. Many of the health problems identified were those resulting from, or contributed to, by lifestyle. Lifestyle risk behaviours were considerably greater among this group of homeless hostel-dwelling men than among the general Irish population.
3. Most of the health problems identified were common symptoms or illnesses. The prevalence of some of these problems was very high, in particular mental health and dental problems.
4. Alongside significant health problems, men reported low levels of social support and poor quality of life by community standards.
5. There was evidence of considerable unmet need in terms of treatment for specific health problems, particularly those relating to mental health.
6. There was high utilisation of all medical services (GP, A&E and out-patient services). These hostel-dwelling men did not appear to use A&E as an alternative to GP services, but rather were high users of both services.
7. Health care delivery through general practice was acceptable to these men. Where used it was associated with high satisfaction and high levels of return visits to the same practitioner.
8. Many men did not have a medical card despite entitlement. Not having a medical card was primarily related to lack of knowledge about the application process or about entitlements. It was not found to relate to administrative difficulties when attempting to apply for a card or to reluctance on the part of GPs to register homeless people in their practices.

Recommendations

1. Solutions and services for these problems should be focused on prevention, health promotion and primary care.
2. In order to reduce behavioural risk factors, a health promotion service for hostel-dwelling men is required which focuses on smoking, alcohol and drug misuse. This health promotion service should be integrated with the services which these homeless men use and should take account of the settings in which health promotion can take place, such as hostels. It should also include training for professionals within the primary care team to provide one-to-one health promotion as well as group activities.
3. The mental health needs of these homeless men requires focused consideration including how, where and by whom such services can be effectively delivered to those most in need.
4. There is a need for education and support for health and related service professionals who deal with homeless men. This would allow an understanding of the specific problems experienced by homeless men to be developed, a reduction of barriers of access to services and the development of health promotion and disease prevention opportunities. There is a reciprocal need for education of staff in the voluntary sector around specific health issues for homeless men and the ways in which primary care for people who are homeless can best be accessed.
5. The proposed introduction of primary care teams with a remit concerning homelessness in the inner city (as outlined in the Eastern Health Board report entitled *Homelessness in the Eastern Health Board: Recommendations of a Multidisciplinary Group* (March 1999)) provides an important mechanism whereby the above recommendations can be realised. These teams should at all times act as a support to primary health care services to facilitate the re-introduction of homeless people into mainstream services. Action plans of these teams should be informed by the findings of the present study.
6. There is a need to develop links between GPs and other primary care professionals, health boards and voluntary agencies. The North and South Inner City GP Partnerships, the GP Unit and the Homeless Initiative are in a position to facilitate these links. This would help to integrate the provision of health services with the other services provided for homeless people, many of which, directly or indirectly, have an impact on health. The unique role of the agency TRUST, in the development of such partnerships to promote the health of homeless men, is acknowledged.
7. The medical card application process for homeless people should be more accessible. This should involve education of homeless men and staff with whom they have contact about entitlements and application procedures. Contacts with the health services should be used as opportunities to determine medical card status and to initiate the application process where appropriate.
8. Researchers, policy makers and service providers in this area should co-operate to ensure that the efforts of each are focused on the best use of resources in the interest of homeless people.

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