# A Picture of Health

A Study of the Health Status and Health Promotion Needs
of Homeless People in the West

Report by the Western Health Board
in partnership with
Galway City Homeless Forum &
Mayo Women's Support Service


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## Executive Summary Introduction

Homeless people have been identified as a group that experience inequality in health and a target group in relation to health promotion initiatives. In developing health promotion initiatives it is important to take account of the broader determinants of health and to address the physical, mental and social well-being of homeless people.

The study aimed to identify the health status and health promotion needs of homeless people in the Western Health Board region. To gain an understanding of the health problems and health promotion needs of homeless people one to one interviews were carried out with homeless people and focus groups were carried out with service providers.

Sixty five interviews were carried out with people currently accessing voluntary services in Galway and Mayo. Three focus groups were carried out with service providers from voluntary and statutory services.

# Findings

## Interview findings

The key findings from the interviews were:

### *Pathways to homelessness:*

- The main factors which led to homelessness were emigration, addiction problems, mental health problems, relationship problems (including violent / abusive relationships), poverty and tenancy problems.
- The majority of people interviewed (71%) stated that, in the past, they had no where to stay. Sixty percent of people described situations where they slept rough / outdoors.

### *Physical & Mental Health:*

- The majority of interviewees (59%) had physical health problems. The most common problems reported were respiratory tract problems, including asthma and bronchitis.
- The majority (58%) of all interviewees reported having mental health problems or illnesses. Forty five percent reported having depression.
- Fifty five percent of people interviewed scored on or above the threshold score of 3 on the GHQ-12 (a test aimed at detecting psychiatric disorders). This compares with 54% of hostel-dwelling men in Dublin (Feeney et al, 2000) and 13% of men from the general Irish population (Fahey et al 1999) who scored on or above the threshold score of 3.
- The main causes of stress were relationships issues (43%) followed by poverty / money problems (26%).

### *Alcohol / Drug Use*

- Fifty five percent of current drinkers scored 2 or greater on the CAGE alcoholism screening instrument indicating alcohol problems.
- Forty two percent of people interviewed who had used drugs scored 1-2 on the Drug Abuse Screening Test indicating low level of problems; 24% scored 3-5 or moderate level problems warranting further investigation. 35% scored over 6 indicating need for intensive assessment.

### *Relationships:*

- Twenty six percent of people were separated or divorced. Most of the women interviewed had experienced violent or abusive relationships.
- The majority (86%) of people interviewed referred to difficulties with relationships.
- Relationship problems included difficulties with family of origin.
- Lack of contact with other people and lack of social support was very common.
- Almost one third of people did not have close, personal relationships.
- Twenty nine percent said that they would turn to staff members in the hostels / houses if they needed help or for some-one to talk to.

### *Services:*

- The main difficulties identified in relation to services were being passed around from one service to another (48%); feeling that a service did not meet one's needs (48%); and not knowing where to go to get a service ( 46%). A third of people interviewed said that they felt they had been discriminated against when trying to use a service.
- Forty seven percent of people interviewed had missed a service or not attended a service when advised to. Reasons for not attending services included negative feelings (fear, shyness etc), feeling that service would not be helpful often due to past experiences and difficulties in relation to time and notification of appointments.
- The majority of suggestions for improved/ additional services were in relation to housing and accommodation (58%); health services (28%) especially additional services for people with addictions; and general improvement to services (23%) including reduction in waiting lists and queues; respectful, non-judgemental services and advertisement of services.

### Health Promotion Plan:

- The majority of people (64%) said that more information would be helpful to them. The greatest information need was information on entitlements.
- Interviewees were asked what would help to improve their quality of life. The majority of suggestions were to have one's own housing/ good accommodation (42%) and getting a job (28%).
- In relation to a health promotion plan 51% of people requested that services be more health-promoting; 11% of people requested health education / information and 15% requested health promotion programmes.
- In response to a list of possible measures to promote the health and wellbeing of homeless people a day centre was rated highest overall (58%) priority and highest first priority (40%).

## Focus group findings

The key findings from the focus groups were:

- The health and well-being of homeless people was described as poor.
- Addiction makes it difficult for those affected to break the cycle of homelessness.
- Mental health problems are very common among homeless people.
- Many of the problems experienced by homeless people stem from violence and abuse.
- The main stresses experienced by homeless people are connected with the whole homeless situation, poverty and lack of access to services.
- Low self esteem is a key factor for homeless people.
- Most homeless people have poor social supports leading to feelings of loneliness and isolation.
- The homeless lifestyle is traumatic, chaotic and unstable.
- Housing need and tenancy issues are priority areas.
- There is a need for further supportive housing and 'move on' accommodation.
- Gaps within services include attitudes and approaches, and a need for more community based and follow up services.
- Health promotion for homeless people should involve empowerment, building self esteem, advocacy and peer support.
- Emotional support provided by staff is important aspect of health promotion
- Provision of a day centre was seen as important to promote the health and well-being of homeless people.

## Recommendations

From the research the following recommendations are made:-

- The recommendations of existing policy and strategies in relation to homelessness and health should be prioritised and the wider determinants of health should be addressed to reduce the inequality in health experienced by homeless people.

- All agencies for homeless people should develop standardised criteria to assess the physical and mental health of homeless people on initial contact with their service. The Western Health Board should facilitate this process.

- Agencies should provide practical advice and information to homeless people on relevant aspects of health.

- Alcohol counselling and treatment services, including outreach facilities, should be reviewed with a view to increasing the uptake of services by homeless people.

- The provision of specialised mental health services and supported housing for homeless people with mental illness should respond to local need in this region. The provision of a mental health social worker and a community psychiatric nursing service for homeless people should be prioritised.

- A mental health promotion programme for homeless people should be developed with the Health Promotion Services of the Western Health Board and relevant agencies.

- Systems should be developed to identify underlying violence and abuse and to offer referral, counselling and other appropriate services. Service providers should be trained in these skills and the guidelines and protocols for professionals providing services to women and children experiencing violence (2003) should be utilised.

- Day facilities should be provided in consultation with homeless people and with a multidisciplinary approach. They should be utilised to build social skills and social networks. Day facilities should include services, information, advice and training for homeless people.

- Opportunities for peer support amongst homeless people should be developed.

- Lifeskills / personal development programmes should be provided for homeless people.
- Opportunities should be developed to build on the strengths of homeless people, to utilise existing skills, and gain opportunities to develop skills and interests.
- Long-term plans for homeless people should address the issues of retraining, employment and housing.
- Provision of additional 'move on' facilities with follow up support should be prioritised by both statutory and voluntary agencies providing services for homeless people.
- Existing housing legislation needs to be enforced in particular the Housing (Standards for Rented Houses) regulations, 1996; the Housing (Rent Books) Regulations, 1993 and the Housing (Registration of Rented Houses) Regulations, 1993. This should include routine enforcement.
- Various media should be utilised to promote the self-esteem of homeless people and to reduce the stigma of homelessness.
- Agencies should work together to improve the level of co-ordination between services and to ensure easy and appropriate referral.
- Measures should be taken to ensure that homeless people have equitable access to essential services such as primary health care.
- A specific location should be provided where homeless people can access information and advice and referral to services. Community based and follow up services should be further developed.
- Opportunities for partnership working and training, within the health board and externally, should be maximised to enable services to be health-promoting in their approach by providing an open, understanding approach, addressing discrimination, providing an equitable services and addressing the issues that affect homeless people.
- Training on issues relevant to homeless people should be developed within statutory and voluntary services, to help ensure that services are fair and non-judgemental.
- Empowerment should be a key principle of health promotion initiatives.
- Relevant, user friendly information on issues such as entitlements and health information and services should be made available to homeless people through voluntary services, Citizen's information centres and welfare offices. Guidelines from the National Adult Literacy Association (NALA) and Health Promotion Services should be considered when producing written material. The use of other media and provision of one to tone information should be explored.
- Support should be provided for homeless people in relation to smoking cessation, healthy eating and safe drinking. This should form part of the programmes provided by relevant services of the Western Health Board.
- Training needs of service providers in relation to health promotion should be assessed by Health Promotion Services of the Western Health Board and appropriate training should be provided in conjunction with other relevant services.

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# Chapter 1 – Introduction

# 1. Introduction

## 1.1 Research Background

Homeless people have been identified as a group that experience inequality in health and as a target group in relation to health promotion initiatives.

In comparison with the general population the health of homeless people is extremely poor (Power at al, 1999, Feeney et al, 2000). Gaps have been identified in relation to health education and health promotion for homeless people. The Homeless Agency's action plan on homelessness in Dublin (2001) highlights the absence of health education or health promotion strategies for homeless people despite the fact that ' homeless people suffer worse physical and mental health than the rest of the population'.

The health of homeless people has been prioritised in national and regional strategy documents. The homelessness strategy 'Homelessness – an integrated strategy' set in place the development of city and county forums to address homelessness. The National Health Strategy 'Quality & Fairness- a health system for you' (DoHC 2001) has as one of its objectives the development of initiatives to improve health of homeless people (AP.21). The need for focused health promotion interventions has also been identified by the National Health Promotion Strategy 2000 – 2005 (Dept of Health & Children), which highlights the increasing numbers of people becoming homeless in this country as a cause for concern.

The Galway City Homeless Forum has, in its Homeless Action Plan for 2002-2004, highlighted the need for targeted health promotion initiatives. The forum is representative of statutory and voluntary sector service providers to homeless people in Galway city. It provides a forum to address issues in relation to the provision of services for homeless people. This research project forms part of one of the strategic aims of the Galway City Homeless Action Plan 2002-2004 (Strategic Aim 1 – Actions 1.3.1-3).

The survey was initiated as a first stage in developing health promotion projects for homeless people in the Western Health Board (WHB) region. An assessment of the health status and health promotion needs was seen as important first stage in the process. A inter agency steering group was established to oversee the project. The steering group includes representatives from the Galway City Homeless Forum and Mayo Women's Support Service. The results of this research will be used to develop a health promotion plan for homeless people in the region, which takes account of the broader determinants of health and addresses the physical, mental and social well-being of homeless people.

## 1.2 Definitions of Homelessness

### *1.2.1 Legal definition of Homelessness*

The Housing Act (1988) gives the legislative definition of homelessness in Ireland, as follows:-

' A person shall be regarded by a local authority as being homeless if-

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

b) he is living in a hospital, county home or night shelter or such institution and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources.

### *1.2.2 Social Definition of Homelessness*

In relation to social definitions of homelessness, O'Sullivan (1996) defines homelessness according to three broad categories of visible homeless, hidden homeless and those at risk of homelessness. These categories are further subdivided as follows-

**Visible Homeless**

| | |
|---|---|
| Shelterless | Sleeping on the streets or in other places not intended for night-time accommodation or not providing safe protection from the elements. |
| Homeless in Shelter | Usual night-time residence is a public or private shelter, emergency lodging or such, providing protection from the elements but lacking 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. (e.g squatting). |

| | |
|---|---|
| Housed but not in homes | In grossly inadequate accommodation, physically substandard and intolerable 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.

## 1.3 Health & Well-being of Homeless People

### *1.3.1 Health Status*

Numerous studies have highlighted the presence of mental and physical health problems in the homeless population. Some of the health problems of homeless people may be as a result of their homeless situation. However, health problems and socio-economic factors are often the cause of homelessness in the first place. (Morrel – Bellai et al, 2000). The main determinants of inequalities in health are socio-economic factors (Burke, 2001). The factors involved include material conditions such as unemployment, lack of access to adequate housing, and psycho-social factors such as poor support networks, (Dept of Health & Children, as cited in Burke, 2001). Many, if not all, of these factors are relevant for homeless people.

### *1.3.2 Health Promotion*

Power et al (1999 pg. 4) state that health promotion includes physical, mental/emotional, social and spiritual dimensions of health. Health Promotion focuses on empowering people to should enable individuals to have control over their life areas to improve their health. It is concerned with addressing all factors which impact on health status including social and environmental aswell as lifestyle and behavioural factors.

Health promotion activity can include a variety of approaches from health education to community development approaches. The Western Health Board strategy 'Promoting Health in the West 2003-8' (2003) strives to promote the health and quality of life of people in the region. Reducing health inequalities and working in partnership, to improve determinants of health, have been identified as necessary to achieve this.

### *1.3.3 Health Promotion & Homeless People*

There have been a limited number of studies focusing on health promotion and homeless people. Power & Hunter (2001) highlighted the need for health promotion interventions targeting homeless and vulnerably housed people. This included basic information on health services, availability of hostel accommodation, first aid, and practical healthcare information such as footcare. The need for co-ordination of information was highlighted. Social networks of homeless people were also explored as possible avenues for conveying health messages. Opportunities for and interest in peer education with homeless people was identified.

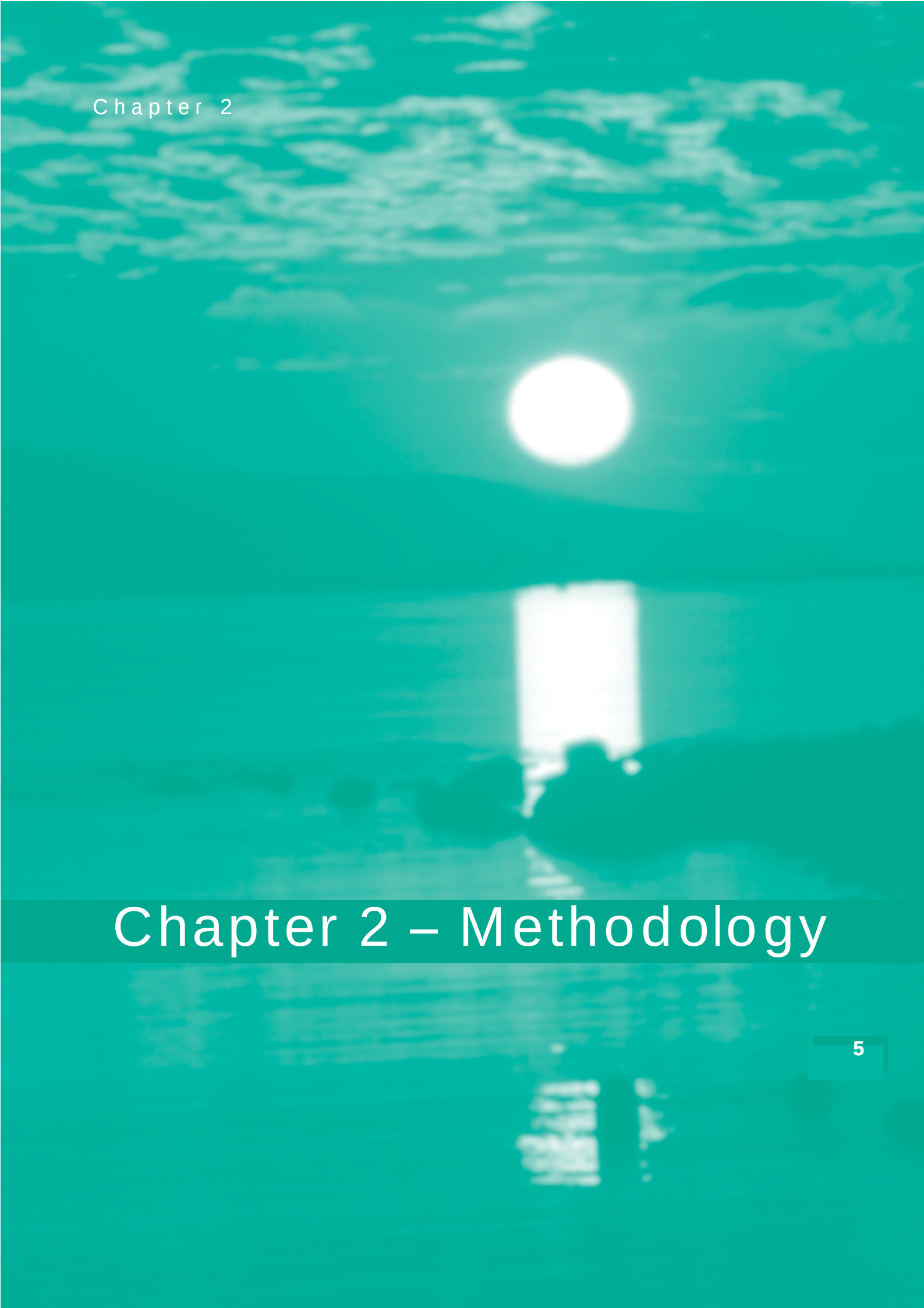
Peer education projects have also been described by Connor et al (1999). In a peer education project implemented by practitioners in a nurse managed clinic for homeless people, previously homeless people attended sessions on peer health education. They then worked in an opportunistic way through one-to-one sessions with homeless people in their area. One of the most successful outcomes of the project in its early stages was the impact on the peer educators themselves in terms of empowerment, increased self esteem and confidence. Power at al (1999) recommend the use of an action research approach in community-based interventions targeting homeless people. Action research has been described as a collaborative and potentially empowering research process (Walters & East , 2001).

## 1.4 Aims and Objectives

The aim of this study was to identify the health status and health promotion needs of homeless people in the Western Health Board region. The result of this survey will be used to inform the planning of health promotion projects for homeless people.

The specific objectives were:

- To gain an understanding of the health problems and health promotion needs of homeless people.
- To explore health concerns of these groups.
- To identify the information needs of this population.
- To investigate health promotion initiatives to respond to identified needs



# Chapter 2 – Methodology

# 2. Methodology

## 2.1 Introduction

In devising the methodology for the research, consideration was given to the following factors:

1. The desire to achieve an understanding of the experiences, thoughts and feelings of homeless people in order to gain an insight into their health promotion needs.

2. The ability of interviewees to communicate their views and perceptions.

3. Challenges in collecting data with homeless people such as literacy difficulties (Power et al (1999).

Qualitative research methods were incorporated in this study. Qualitative methods are considered useful for exploration of topics and groups that are poorly understood (Morgan 1998). They enable the researcher to explore in more depth the thoughts, feelings and experiences of research participants. The use of focus groups and interviews add rich, contextual data (Power at al, 1999).

One to one interviews have been shown to be effective in the past when undertaking research with homeless people. For the purpose of this study they were considered less threatening than group interviews and more appropriate than questionnaires.

In addition to interviewing homeless people, it was also considered important to gain the additional perspective of service providers in statutory and voluntary agencies who work directly with homeless people.

Therefore, there are two stages to the research
i. Interviews with homeless people
ii. Focus groups with service providers

## 2.2 Steering Group

An interagency steering group was established to plan and oversee the study. The steering group included representatives from the Galway Homeless Forum and Mayo Women's Support Service. Group discussions were undertaken to highlight issues relating to health and health promotion for homeless people that should be explored. This ensured that all key issues of concern were included in the research. The steering group provided input to and facilitated all subsequent stages of the research.

The following individuals were members of the steering group:
Andy Bourne, SIMON community
Bernadette Byrne, Mayo Women's Support Service
Patricia Doherty, Psychiatric services, WHB
Mary Falvey, Cuan Mhuire
Mary Gibbons, Cope, Westside House
Colm Noonan, St. Vincent de Paul

## 2.3 Interviews

### *2.3.1 Interview schedule*

The survey involved semi-structured one-to –one interviews with homeless people currently accessing services of voluntary agencies in the region. Semi-structured interviews were considered most appropriate as they can supply rich and useful data. Participants may be able to share their personal experiences, thoughts and feelings better in a one-to-one situation.

An interview schedule was developed in consultation with the inter agency group (See Appendix 1). Interviews were used to explore health concerns of participants. A broad definition of health was used to gain an understanding of physical, mental, social & environmental needs. Information on service, information and health promotion needs was also gathered.

Some sections of the interview were conducted using standardised questionnaires, as follows:-

i) The General Health Questionnaire which was designed to be a self-administered screening test aimed at detecting psychiatric disorders (Goldberg, 1978). The GHQ-12 is a shortened version which is equally valid and reliable (Goldberg, 1992, Bowling, 1997). The GHQ-12 was used in a recent study of hostel dwelling men in Dublin as a general measure of psychological distress.

ii) The CAGE Questionnaire which is an alcoholism screening instrument. It has been evaluated in several studies (NIAAA, 2002). It poses four straightforward yes / no questions which eases administration.

iii) The Drug Abuse Screening Test (DAST – 10) is a screening tool for drugs other than alcohol (Addiction research foundation, 1982). A score of 1-2 indicates low level of problems related to drug abuse; 3-5 indicates moderate level warranting further investigation; and 6-8 indicates a substantial level of problems related to drug abuse requiring intensive assessment.

The interview schedule included the following broad areas:-

- Current situation of participants
- Pathways into homelessness
- General health status
- Physical well-being
- Mental / emotional well-being
- Social well-being
- Spiritual well-being
- Environmental well-being
- Services
- Health promotion needs

The interview schedule was piloted with seven homeless people in Limerick city to access comprehensive and appropriateness of questions. Amendments were made and the final interview schedule was developed.

### *2.3.2 Administering of interviews*

The interviews were conducted by interviewers, who were recruited from women's support services and recent graduates from health promotion and psychology, and the researcher. A half-day training session specific to the survey was provided for interviewers. A training pack was provided to be used as a reference manual. Guidelines for interviewers were drawn up in consultation with the Steering Group of the Galway City Homeless Forum and the steering group overseeing the research, on dealing with difficult situations.

Interviewees currently residing in hostels or homes for homeless people were engaged through the various voluntary agencies providing those services. It was decided, with the steering group, that all people residing within those settings would be invited to take part in the study. Interviews were carried out over a four week period between November and February 2002-3. Fifty eight interviews were carried out with people using the services of the following agencies in Galway city :-

- St. Vincent de Paul
- COPE
- SIMON

Seven interviews were undertaken with Mayo Women's Support service refuge in Castlebar and transitional housing in Ballina.

In addition, efforts were made to involve street homeless, that is people sleeping rough. Anecdotal evidence indicated that the number of street homeless in the city at the time of the study was very small. Attempts were made to engage street homeless through the emergency hostels, St. Vincent de Paul and other service providers. This was not successful and this group was not involved in the research.

For the purposes of this study, 'homeless people interviewed' and 'interviewees' refers to people residing in shelters or other accommodation provided by voluntary services and who, without such support, would not have a home. Women residing in emergency or refuge accommodation were included as they are classified as homeless while in receipt of such services. A small number of interviewees had very recently moved into rented or local authority housing and were still receiving support from voluntary agencies.

Initial permission was gained from each individual before carrying out the research. Informed consent was obtained and a description on the nature of the research was given. The participants were reassured that they could 'pass' on any questions that they did not wish to answer.

A series of cue cards were used to facilitate the process of the interview and to assist people who may have had literacy difficulties. This was particularly useful for structured questions with scales. At the end of interviews, interviewees were asked if they would like support on any issue that was brought up in the interview. A list of contact numbers was offered by the interviewers.

## 2.4 Focus Groups

In addition to interviewing homeless people about their health and health promotion needs, focus groups were carried out with people providing services to homeless people in the region. Focus groups help to generate a rich understanding of participants' experiences (Morgan 1998) & assisted in gaining a greater insight into the needs of homeless people.

Homeless people may find it difficult to express their needs. Service providers who work directly with homeless people have insight into the needs and concerns of people they have worked with. They were in a position to draw on their experiences of working with this client group in suggesting appropriate health promotion initiatives.

A topic guide (see Appendix 2) was developed to use as a framework to create discussion within the group. The topic guide was based on the following themes:-

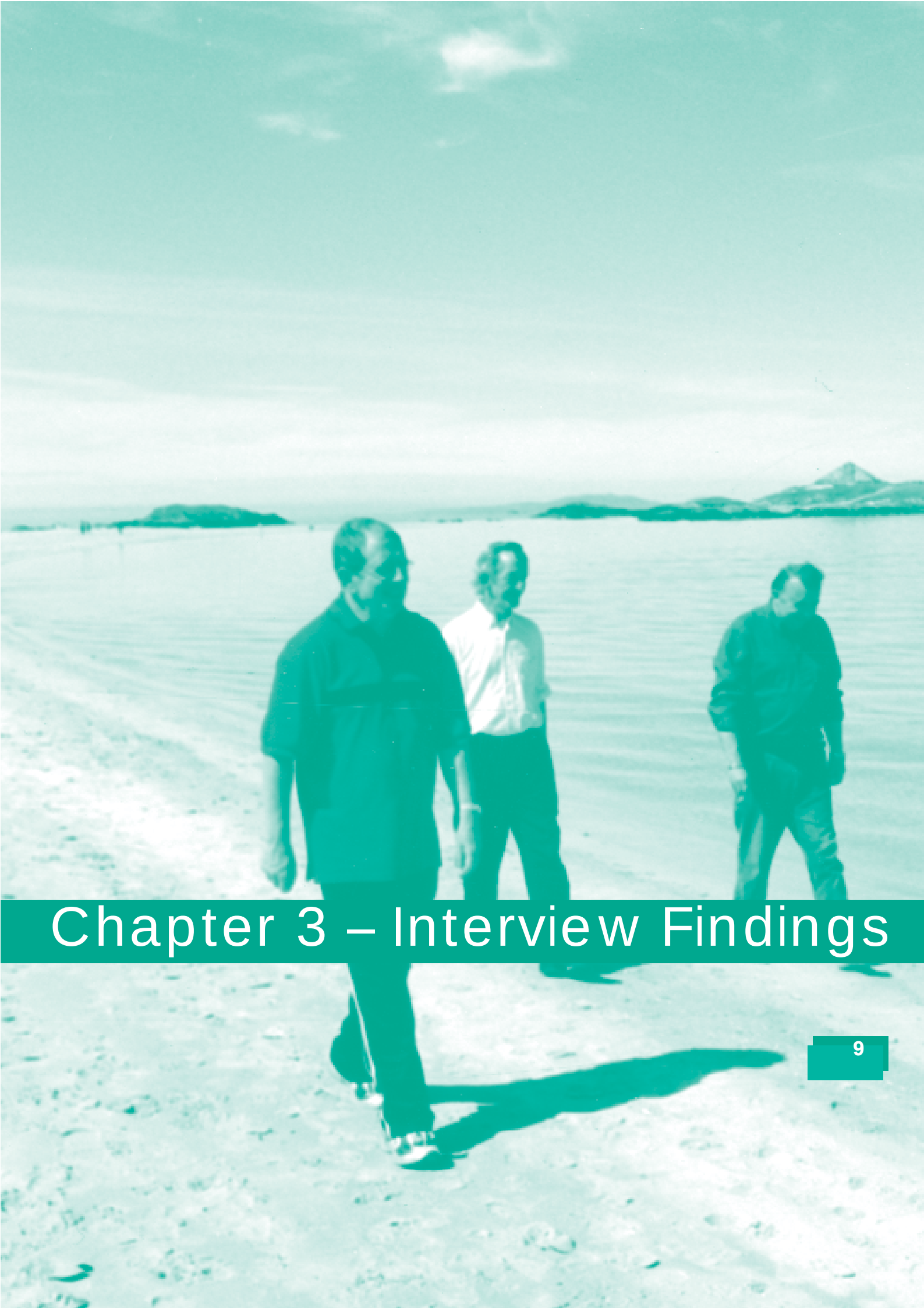
- Health & well-being of homeless people
- Services are currently used by homeless people

- Changes / improvements to services
- Health promotion for homeless people

Three focus groups were carried out with service providers in the Western Health Board region. Participants were representative of statutory and voluntary agencies who provide services to homeless people in the region. Participants were invited from agencies represented at the Galway City Homeless Forum and Mayo Women's Support Service. Front-line staff, who work directly with homeless people, were involved in the focus groups. Twelve organisations were represented .

### 2.5 Data Analysis

All interviews were transcribed verbatim. Quantitative data was analysed using the SPSS quantitative analysis package. Qualitative data was coded into themes and once coded entered into the Nvivo qualitative research programme. Focus group discussions were recorded and transcribed. Data from focus groups was coded and entered into the Nvivo programme. Nvivo is a software programme that simplifies the sorting and retrieval of coded segments to facilitate analysis.



# Chapter 3 – Interview Findings

# 3. Interviews

## 3.1 Introduction

Interviews were undertaken to gain an understanding of the health status and health promotion needs of homeless people. This involved exploring physical, mental, social & environmental well-being, use of services and health promotion needs. A total of 65 interviews were undertaken with homeless people accessing voluntary services in Galway and Mayo.

## *3.2 Demographic Profile*

As highlighted in Table 3.1, 63% of interviewees were male and 37% female. There was a broad age range, with the majority (26%) in the 35 to 44 age bracket. The majority (69%) of people interviewed were single, with 17% separated and 9% divorced. The vast majority of those interviewed (89%) were Irish. A total of 40% of interviewees had children under 18 years of age (Table 3.2)

Table 3.1: Age Group, Marital Status and Gender

| Age, Marital Status and Gender | | | |
|---|---|---|---|
| | | No. | % |
| Age Group | 18-24 | 9 | 14 |
| | 25-34 | 12 | 19 |
| | 35-44 | 17 | 26 |
| | 45-54 | 10 | 15 |
| | 55-64 | 7 | 11 |
| | 65+ | 10 | 15 |
| Marital Status | Single | 44 | 69 |
| | Married | 1 | 2 |
| | Separated | 11 | 17 |
| | Divorced | 6 | 9 |
| | Widowed | 2 | 3 |
| Gender | Male | 42 | 63 |
| | Female | 23 | 37 |
| Nationality | Irish | 58 | 89 |
| | British | 5 | 8 |
| | Non EU citizen | 2 | 3 |

Table 3.2: Children

| | No. | % |
|---|---|---|
| No. of people who have children | 29 | 45 |
| No. of people who have children under 18 | 26 | 40 |

Table 3.3 shows that the majority of people whose nationality is Irish were originally from Galway (47%) with 16% from Dublin, and the remainder from other counties in Ireland or Northern Ireland.

Table 3.4 shows that the majority of people (37%) were residing in their present county for ten years or more, with 29% residing in their present county for one to ten years and 30% for less than a year.

Table 3.3: County of origin

| County | No. | % |
|---|---|---|
| Galway | 27 | 47 |
| Dublin | 9 | 16 |
| Cork | 5 | 9 |
| Mayo | 4 | 7 |
| Limerick | 2 | 3 |
| Louth | 2 | 3 |
| Westmeath | 2 | 3 |
| Northern Ireland counties | 3 | 5 |
| Other counties | 4 | 7 |

Table 3.4: Length of time living in present county

| Time | No. | % |
|---|---|---|
| <1 month | 3 | 5 |
| 1-5 months | 11 | 17 |
| 6-11 months | 6 | 8 |
| 1-10 years | 19 | 29 |
| More than 10 years | 24 | 37 |
| Not stated | 2 | 4 |

## 3.3 Current Accommodation

The current accommodation of people interviewed is given in Table 3.5. It can be seen that interviewees resided in a wide variety of locations, with the greatest proportion residing in the Fairgreen hostel (32%).

Table 3.6 shows that 26% of interviewees had been living in their present accommodation for up to one month with 46% living there for up to a year and 26% in their present accommodation for one or more years.

Table 3.5: Current Accommodation

| Current accommodation | Agency | No. | % | Total no of residents at time of interview |
|---|---|---|---|---|
| St Anthony's Galway | St Vincent de Paul | 11 | 19 | 14 |
| Fairgreen | Cope | 19 | 32 | 26 |
| Waterside House | Cope | 1 | 2 | 6 |
| Westside House | Cope | 2 | 3 | 2 |
| Ashley House | Cope | 5 | 9 | 5 |
| Fr. Griffin Rd | SIMON | 2 | 3 | 4 |
| Dyke Rd | SIMON | 2 | 3 | 7 |
| Hazel Park | SIMON | 4 | 7 | 4 |
| Rocklands Ave | SIMON | 4 | 7 | 5 |
| Corrach Bui | SIMON | 5 | 9 | 5 |
| Women's refuge | Mayo Women's Support Service | 1 | 2 | - |
| Transitional Housing | Mayo Women's Support Service | 3 | 5 | - |
| Private rented | | 4 | 7 | - |
| Council hse / flat | | 1 | 2 | - |
| Simon house not specified | | 1 | 2 | - |

## 3.4 Pathways to homelessness

Interviewees were asked how they came to be living in their current accommodation and where they were living before that. They described a complex series of factors which led to them being homeless. The main factors were emigration, addiction problems, mental health problems, relationship problems, poverty and tenancy problems. These themes recur not only in people's descriptions of their pathways into homelessness but also throughout the interviews and in descriptions of causes of stress and experiences of homelessness. Many factors were interlinked and most people experience a number of these issues. Some issues appeared to be both a cause of and a consequence of homelessness. Each of these factors will now be outlined in more detail.

Table 3.6: Length of time living in present accommodation

| Time | No. | % |
|---|---|---|
| <1 week | 4 | 6 |
| 1-3 weeks | 13 | 20 |
| 4 weeks-5months | 23 | 35 |
| 6-11 months | 7 | 11 |
| 12 months-5 years | 12 | 18 |
| 6-10 years | 3 | 5 |
| 11-20 years | 2 | 3 |

### *3.4.1 Emigration*

Many described experiences of emigration and difficulties on returning to Ireland. For some people on returning to Ireland they experienced loneliness and had a lack of social contact in their home country:

> *"Can't settle at all. Away from home since '74. Moved about a lot. In England from '74 to '91 . . . Couldn't settle. . . . When you living away for as long as I was it's like a strange place coming back"*

Emigration and living in foreign countries was also a lonely experience. Lack of interpersonal relationships and human contact was linked to depression:

> *"Seen a lot of fellas never married, a lot of depression, taking tranquilisers. Seen a lot of suicides. No home for them to go back to and no-one calling. Pub is all they've got."*

Emigration was often associated with excessive use of alcohol. This became a way of life and a way of keeping contact with others:

> *"I had enough of England, on streets in the later stages. 8 weeks on drink St. Patrick's day. Never went back to the house. On streets in Summer, cipping with others. Gets in head, lost the place. Fellas dossed and worked and were homeless. Hit rock bottom with drink, but never hit hostels, you'd always get a lie down. Took a long time to clear my head."*

### *3.4.2 Alcohol & drug problems*

Many participants described alcohol and drug problems as being the cause of homelessness:

*"Alcohol is the reason I'm homeless, and my biggest struggle is to stay off the drink, but if I can do that I will be able to get back on my feet again."*

*"If you have a drug problem you can't keep anything down I lost everything I was on the street."*

The reasons for excessive alcohol and drug use were not always clear. However in many cases relationship problems were described.

### 3.4.3 Relationships

Relationships were often mentioned in descriptions of events leading to homelessness.
Difficulties with family of origin included experiences of parental aggression and violence. For some this was linked to parental alcoholism:

*"Father (was) aggressive, I suffer in silence had to leave room."*

*"Parents were violent towards each other and with drink I used to have to break them up and very violent towards me that's why I left home."*

*"Father was an alcoholic, very strict (there were) 10 of us".*

Lack of attachment in childhood was experienced by some people interviewed:

*"Mother no interest in whether I lived or died."*

*"Never had a family, all over the place . . . hard to find somewhere to call home"*

Some men referred to marriage break up or separation as a precipitating factor in being homelessness

### 3.4.4 Violence and Abuse

Many of those interviewed had experienced violence and abuse. In some cases this occurred when they were children, while for others it recurred throughout their lives, involving parents, partners and other individuals:

*"I used to live in _____, but my husband used to beat me so I was forced to leave and move into a flat in _____, I was abused all my life, when I was a child I was abused but no-one believes me."*

*"I have been on my own since I was three and a half. Always had to look after myself, so I just do what I got to do. I was as abused as a child, never felt loved. The family kept the abuse a secret among themselves and I was not allowed to mix with others mainly because of this. I was abused by a Catholic priest, physically beaten and sexually assaulted."*

Many women referred to domestic violence, others spoke of difficulties with their partner and alluded to domestic violence.

### 3.4.5 Mental Health Problems

Mental health problems and depression in particular were frequently reported by those people interviewed. Many referred to depression and need of support services as the reason for requiring sheltered accommodation.

### 3.4.6 Poverty and Tenancy problems

Tenancy issues eventually led to homelessness for many people:

*"Was living in a flat in Dublin. The landlord died, his son took over and told me I had to leave. I was forced to sleep rough on the streets of Dublin when there was no room in hostels, so I moved to Galway for a change."*

Poverty meant that people could not afford accommodation or lost accommodation when they could not meet payments. Some people described substandard accommodation. Difficulty securing private rented accommodation was also highlighted. The main problems were the amount of money required for deposit or rent, and landlords not accepting tenants who are on rent receipts:

*". . . . things got pear shaped every so often, lost flat it's impossible to get a place if you are not working- large deposits they don't do rent receipts - (landlords) get taxed or fined anyway."*

*"3 kids was expecting fourth child. Separated from husband in U.K. wanted to come home to family in Ireland. Was look for private*

*accommodation but that failed, so had no other option. Still, found it hard to private accommodation. Landlords wouldn't give rent receipts etc ., or price too high or wouldn't accept children."*

## 3.5 Physical & Mental Health

Taking exercise, taking care of diet and taking medication were the main ways in which interviewees reported that they look after their health (See table 3.7).

Table 3.7: Ways to look after Health

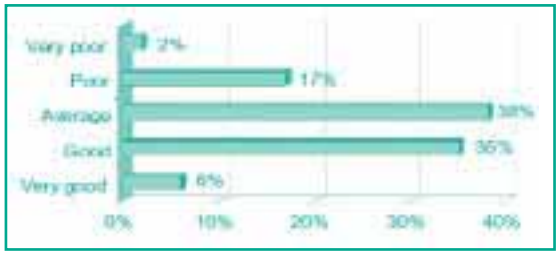
| Way to look after health | No. | % |
|---|---|---|
| Take tablets for mental health | 7 | 11 |
| Take tablets for physical health | 5 | 8 |
| Eat healthy / sufficiently | 12 | 18 |
| Walk | 13 | 20 |
| Exercise | 5 | 8 |
| Swim | 3 | 5 |
| Don't drink | 3 | 5 |
| Go to doctor / psychiatrist | 3 | 5 |
| Gave up smoking | 2 | 3 |
| Mentally occupy myself / keep busy | 2 | 3 |
| Wash teeth | 2 | 3 |
| Other | 10 | 15 |

* Multiple response, therefore percentages may not add up to 100%

### *3.5.1 Rating of Physical Health*

Interviewees were asked to rate their physical health on a five point scale from very good to very poor. Figure 3.1 shows that the majority (41%) rate their physical health as good or very good with 39% rating their health as average and 19% rating it as poor or very poor.

Figure 3.1 Rating of own Physical Health




The majority (59%) of interviewees had physical health problems. Table 3.8 shows that the most common problems reported were respiratory tract problems, including asthma and bronchitis.

### *3.5.2 Rating of Mental Health*

Interviewees were asked to rate their mental health on a five point scale from very good to very poor. Figure 3.2 shows that compared to a survey that asked the general population to rate their mental health (Evans & Jones, 2001) the homeless people interviewed rated their mental health significantly less favourably. A total of 50% of homeless people rated their mental health as good or very good, compared with 86% of respondents from the general public. A total of 19% of homeless people rated their mental health as poor or very poor compared to just 1% of the general public.

Table 3.8: Physical Health Problems / Illnesses

| Physical Health Problems / Illnesses | No | % |
|---|---|---|
| Bronchitis/ chest infections | 7 | 11 |
| Asthma | 6 | 9 |
| GIT problems (incl ulcers) | 6 | 9 |
| Joint problems / arthritis | 5 | 8 |
| Back problems | 5 | 8 |
| Kidney problems | 4 | 6 |
| Eye problems | 4 | 6 |
| Hepatitis / HIV | 4 | 6 |
| Skin problems | 4 | 6 |
| Fractures | 3 | 5 |
| Circulation problems | 3 | 5 |
| Migraine | 3 | 5 |
| High blood pressure | 2 | 3 |
| Cardiac disease | 2 | 3 |
| Other | 18 | 28 |

* Multiple response, therefore percentages may not add up to 100%

Figure 3.2: Rating of own Mental Health


Fifty eight percent of interviewees reported having mental health problems or illnesses (Table 3.9). Forty percent reported having depression. Thirty four percent of people said that they were on medication for mental illness, now or in the past. Fifteen people (23%) stated that they are on medication for depression. Two people said that they were on medication for stress and 1 person said that they were on medication for mental health. Four people had stopped taking medication for depression.

### *3.5.3 General Health Questionnaire*

The General Health Questionnaire is a screening test aimed at detecting psychiatric disorders (Goldberg, 1978). The GHQ-12 was used in a recent study of hostel dwelling men in Dublin as a general measure of psychological distress.

Table 3.9: Mental Health Problems / Illnesses

| Mental Health Problems / Illnesses | No | % |
|---|---|---|
| Depression | 26 | 40 |
| Maniac depression | 2 | 3 |
| Anxiety | 5 | 8 |
| Mood disorders | 2 | 3 |
| 'Feeling depressed' – not diagnosed | 2 | 3 |
| Schizophrenia | 1 | 2 |
| Total | 38 | 58 |

* Multiple response, therefore percentages may not add up to 100%

Table 3.11 shows that 55% of people interviewed scored on or above the threshold score of 3 on the General Health Questionnaire - GHQ-12. This compares with 54% of hostel-dwelling men in Dublin (Feeney et al, 2000) and 13% of men from the general Irish population (Fahey et al 1999) who scored on or above the threshold score of 3 indicating psychological distress.

Table 3.11: General Health Questionnaire

| GHQ Score | No | % |
|---|---|---|
| Score | | |
| 0 | 17 | 27 |
| 1 | 5 | 8 |
| 2 | 8 | 13 |
| 3 | 4 | 6 |
| 4 | 6 | 9 |
| 5 | 4 | 6 |
| 6 | 2 | 3 |
| 7 | 1 | 2 |
| 8 | 4 | 6 |
| 9 | 3 | 5 |
| 10 | 4 | 6 |
| 11 | 3 | 5 |
| 12 | 3 | 5 |

### *3.5.4 Experiences of Mental Health Problems*

Many interviewees reported that they experienced mental health problems and depression. Mental health problems were often associated with negative past experiences:

> *"Things have been bad for years. Couldn't care less anymore. Suffered from depression in past on medication but stopped taking it because it didn't do any good. Now that I am away from my past not feeling like that anymore."*

Living with depression involved dealing with the recurring nature of the illness. Some reported being good one day and bad the next. Others described how it could 'strike' at any time. Several people had experienced suicidal thoughts and a number described suicide attempts:

> *"Things I want to do but something's telling me not to do it like taking overdoses."*

> *"I suffer from depression and am on medication. I tried to commit suicide 4 times in the last few years, tried to hang myself twice, tried to drown myself by jumping in the river, put a gun into my mouth, but was interrupted before I pulled the trigger."*

Being homeless contributed to depression and mental health problems. One woman illustrated the day to day trauma of sleeping rough and the effect on her mental health:

> *"Moving from one place to another. Hungry, tired, wet, depressed. Not knowing what to do the next day. Just get up and walk the streets. Depressed. I had my wrist cut."*

Experiences of medication use varied. Some people found medication to be of benefit, while others preferred to stop taking medication and others experienced side effects:

> *"Depression - like a vicious circle. On tablets, drinking and wouldn't take tablets. One around gives you one tablet and the other says not to it doesn't suit you. I (don't) trust myself with tablets. I have taken a few overdoses"*

> *"Manic depression. I take 3 different types of medication including Valium, which I find very good. I would be lost without medication."*

> *"I was on tablets for depression I didn't like it so I cope on my own."*

## 3.6 Stress

Interviewees were asked to identify their main causes of stress and the ways in which they normally deal with stress.

### *3.6.1 Dealing with stress*

The main ways of dealing with stress were walking

Table 3.10: Dealing with Stress

| Ways I deal with stress | No | % |
|---|---|---|
| Walk | 11 | 17 |
| Take medication / tranquillisers | 7 | 11 |
| Drink (alcohol) | 7 | 11 |
| Talk to some-one | 6 | 9 |
| Relax / meditate | 5 | 8 |
| Pray | 5 | 8 |
| Listen to music | 5 | 8 |
| Smoke | 5 | 8 |
| Take myself off on my own | 3 | 5 |
| Watch TV | 3 | 5 |
| Think it over | 3 | 5 |
| Other | 20 | 31 |

* Multiple response, therefore percentages may not add up to 100%

(n=11), taking medication (n=7) or drinking alcohol (n=7). 6 people said that they would talk to some one to deal with stress.

### *3.6.2 Causes of Stress*

The main causes of stress were relationships issues (43%) followed by poverty / money problems (26%). Fourteen percent of people interviewed didn't cite causes of stress or said that they were not stressed at the moment.

**Relationship issues**

Some people spoke of stress associated with loneliness and their difficulty in making contact or developing relationships with other people. For other people lack of contact with family was a cause of stress. Problems with ex-partners caused stress for many people, especially women receiving support services:

> *"The most stress this time is pressure from my family and _____ (ex-partner), if he's not around we're OK"*

> *"I feel if my husband came back on the scene I would be very stressed out. I would feel very anxious about seeing him when I go to court for my separation."*

One woman spoke about hopes for the future and putting problems with her ex-partner behind her. Her positive outlook was associated building relationships with others:

> *"I feel good now because I want to forget about problems to start a new life…. afresh. I have a lot of friends now that I didn't get before because he didn't want me to have friends. My ex-partner causes me most stress in my life."*

Many people expressed concern about family members or children as a source of stress. For some this was associated with poverty and being unable to provide for their family. Others were concerned about difficulties experienced by their children and with their children being homeless.

**Poverty / Money problems**

Stress in relation to poverty and money problems was very common. Lack of money limited people's option for leaving support accommodation and finding somewhere to live:

> *"Money problems if you don't have enough money to live somewhere, not knowing where to go to next."*

> *"Money and having no where stable to live for the kids. This set up is fine but its only short term."*

Poverty was also associated with unemployment. Difficulties in getting employment meant that people could not break the cycle of poverty.

**Past experiences**

Some referred to stress in the past and compared their situation now with past stressors:

> *"Nothing don't get stressed. I might think about my past that's their problem not mine. I know I am good person."*

> *"Four years ago would be stressed . .. Can take drink or leave it. Used to have money worries. Take one day at a time (now)"*

> *"Being Homeless, Concerns about the future."*

Being homeless was also identified as a cause of stress. Lack of support and help added to the stress of the homeless situation:

> *"Family always on the go and don't have any help, get stressed out and that brings on illnesses."*

> *"Having no where to live. No-one to help me out."*

Treatment by other people compounded feelings of stress:

> *"People treat you differently because you are homeless."*

Some people expressed lack of security about their current situation and fears of being on the streets again. One man highlighted the frustration of waiting for a change in fortune:

> *"I want things to happen too fast. I want to get a job, a flat, a girlfriend all in the one week. I hate hanging around waiting for my luck to change."*

**Alcohol**

A number of people spoke of stresses associated with drinking:

> *"Drink is my down fall have no worries only that."*

Fear of relapse was also expressed. Drinking was also associated with money problems and relationship problems:

> *"When drinking money problems - want money to buy drink. When not drinking I don't get stressed, Due to previous drinking, my family don't want anything to do with me."*

**Health**

Physical and mental health problems were sources of stress for several people. A number of people referred to sensitivities associated with their mental health problem

**Other stressors**

Other stressors identified were day to day worries, frustration with services and difficulties associated with returning from overseas

## 3.7 Social Well-being

### *3.7.1 Interactions and Relationships*

The vast majority (84%) of people interviewed have people that they considered to be important in their life. A total of 68% have close, personal relationships. Close, personal relationships were mainly with relatives (25%) or friends (25%). Fourteen percent of interviewees said that they had close, personal relationships with staff members / other service providers (Table 3.12).

Table 3.12: Close, personal relationships

| | No | % |
|---|---|---|
| Family / Relatives | 16 | 25 |
| Friends | 16 | 25 |
| Staff in house / hostel | 9 | 14 |
| Boy/ girlfriend / partner | 5 | 8 |
| Friends in house / hostel | 3 | 5 |
| Social worker | 4 | 6 |
| Support group | 2 | 3 |
| Staff in psychiatric clinic | 1 | 2 |
| Neighbours | 1 | 2 |
| Other | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

Sixty two percent of people identified other people that they have regular contact with. The identified people that they meet in the hostel or other sheltered accommodation.

Table 3.14: Who would you turn to?

| Who would you turn to if you need help or to talk about things? | No | % |
|---|---|---|
| Staff in house / hostel | 19 | 29 |
| Family / Relatives | 17 | 26 |
| Friends | 8 | 12 |
| Social worker | 5 | 8 |
| Other staff | 3 | 5 |
| Other residents in house / hostel | 2 | 3 |
| Addiction counsellor / counsellor | 2 | 3 |
| Anybody I'd know / whoever I'd be happy with | 2 | 3 |
| Boy/ girlfriend / partner | 1 | 2 |
| Nurse | 1 | 2 |
| Psychiatrist | 1 | 2 |
| Priest | 2 | 3 |

* Multiple response, therefore percentages may not add up to 100%

Staff members in the houses / hotels were identified by 29% of interviewees as people that could be turned to if help was needed or for some one to talk to (Table 3.14).

### *3.7.2 Difficulties with Relationships*

The majority (86%) of people interviewed referred to difficulties with relationships. For many, relationship difficulties were with family of origin. These included difficulties with parental relationships, aggressive or violent family relationships, strained relationships or loss of contact with family members. Several people had experienced traumatic childhood experiences including violence, abuse and lack of attachment with parents.

As highlighted in the demographics section 26% of

the people interviewed with were separated or divorced. Many people spoke of difficulties with their relationships with a spouse or partner. Most of the women interviewed had experienced violent or abusive relationships. These issues were also associated with pathways to homelessness.

Lack of contact with other people and lack of social support was very common. Many people did not turn to other people for emotional support. In some cases there was a sense of self-reliance:

> *". . . try to work things out in my head. Try to take positive out of negative. I really feel I need to talk to some one but who? I lost touch with the general stream of life. Very hard to be positive in a place like this. Feeling like your not offering anything. Try to get through as best I can."*

> *"I can cope on my own, I don't have to rely on friends."*

Alcohol problems were identified as both a cause of and a consequence of relationship problems:

> *"Marriage broke up . . . I was out drinking then."*

> *"When drinking lost contact with my family but re-united since stopped drinking"*

### 3.7.3 Communication and Social contact

Several interviewees expressed feelings of loneliness. Loneliness was, in some cases, associated with loss or bereavement:

> *"I feel lonely sometimes, my wife died 4 years ago, you sort of lean on each other when there's only two of you."*

Loneliness was also associated with being homeless and difficulty in making attachments. One man described a cycle of homelessness, low self-esteem and loneliness:

> *"Loneliness, don't find it easy to talk to strangers. Self-esteem is gone through the floor. Don't want to be seen or heard. Beginning of year (was) terrible walking around like a tramp. Out of sight, out of mind don't see me falling around streets. Somedays little things fall into place, things are ok. Other days get into a rut, lock myself away, keep away from people."*

Other people had difficulty in communicating with people or talking about their problems. Several people referred to themselves as loners:

> *"Not one for talking to people much. . . . Not a person for sharing my feelings much"*

> *"I don't really have anyone to talk to. I can't talk to my family about my current situation."*

> *"I don't talk to anyone. I can't trust anyone else, so I deal with things by myself."*

Difficulty in maintaining social contact was attributed to lack of trust or confidence in building relationships, often due to past experiences:

> *"(I want) to build up my confidence to enable me to not be frightened of meeting people. Sometimes I don't be as trusting towards strangers after what my husband did to me."*

> *"Developed very untrustworthy thing about people. Don't confide in anyone. Don't know if it was when my wife was acting up behind my back and I was the last one to know. Couldn't trust anyone after that. I would like more contact with people at the same level as I'm at."*

> *"Recently broke up with my girlfriend who was the only person I really trusted, now I don't have any real friends"*

Potential for support from other residents in the hostel was highlighted

> *"There are a lot of similar problems here, drink, relationships, and we can all relate to each other."*

A number of people had experienced problems as a result of bereavement. For some people, alcohol was used to help cope with bereavement. For others bereavement led to mental health problems, a break down in relationships or escalation of problems in relationships:

> *"Breakdown 25 years ago after my wife died. 9 years out of 20 in hospital."*

> *"Hit alcohol when my mother died."*
> *"I fell out with dad when my mother died, I blamed him for a lot of things."*

### 3.7.4 Increasing Social Contact

Interviewees were asked what would help them to have more contact with other people. Forty six percent of people couldn't come up with suggestions or said that they did not want anymore contact. The suggestions that were made are shown in Table 3.15. It can be seen that a wide variety of responses were received with no overall pattern emerging. The most frequently stated responses were having a job (6%), use of a phone (6%) and groups with others in a similar position (6%).

Table 3.15: What would help you to have more contact with other people

| | No | % |
|---|---|---|
| A job / being back in the workforce | 4 | 6 |
| Use of a phone / mobile | 4 | 6 |
| Groups with others in a similar position (mother & toddler, alcoholics) / education groups | 4 | 6 |
| Finance / money to visit family / move out of here | 3 | 5 |
| Leading a normal life | 3 | 5 |
| More Confidence | 3 | 5 |
| Staying off drink | 2 | 3 |
| Having a home | 2 | 3 |
| Better social life | 2 | 3 |
| Talk to doctor / counsellor if needed to | 2 | 3 |
| 1 to 1 confidential meetings | 1 | 2 |
| An employment centre | 1 | 2 |
| To be located closer to people | 1 | 2 |
| To have people's contact numbers | 1 | 2 |
| Contact with the opposite sex | 1 | 2 |
| Going for coffee | 1 | 2 |
| Going to church | 1 | 2 |

*Multiple response, therefore percentages may not add up to 100%

### *3.7.5 Violence and abuse*

Several interviewees spoke about abusive relationships. A number of people stated that they had been abused as children. Most of the women interviewed said that they had experienced of abusive relationships and domestic violence. While some did not want to elaborate on their experience wishing to put it behind them, others spoke of the trauma caused by domestic violence for them and their families. In some cases abuse was recurring. Some women who had been abused as children also experienced rape and abusive relationships with partners. The impact of domestic violence was emphasised by some women who spoke of living in fear and finding it difficult to build trusting relationships with others. Fear for the safety of their children was also expressed:

> ***"I felt so scared of what will happen to us. It doesn't matter for just me but with kids you don't know, I feel scared."***

> ***"Scary, not knowing where to go or what to do. It's like jumping into the unknown. Very black."***

The support of services was highlighted:

> ***"I felt relief and safe coming into refuge. However there were some good times in the house and ideally I would have like to stay in the home if possible but I was too scared. I suffered a lot there too, so on the whole, I felt happier going into refuge."***

A number of women spoke of their desire to rebuild their lives for themselves and their children. The need for further services for women and children was emphasised. Other suggestions included an information service and counselling service for women who have experienced domestic violence:

> ***"There is not enough support there for children, for disturbed children suffering abuse, bullying. Even grown ups - more support to help people like that."***

> ***"24 Hour information centre. For women having to leave their homes, they have to go without money or clothes or any belongings. If they don't have family they have no where to go and no information available to them."***

Other experiences of violence reported included instances where people had been victims of street violence, targeted because they were homeless.

### *3.7.6 Attitudes towards homeless people*

Several interviewees spoke about attitudes towards homeless people. In the main public attitudes towards homeless people were seen as negative. A general lack of understanding and stereotyping of homeless people was identified. Stigma and discrimination in relation to homeless people was described. Some people called for greater understanding towards homeless people and a non-judgemental approach in services:

*"The media should play a more homeless-friendly role and should portray homeless people in a more positive light and should highlight their plight. Homeless people should be able to integrate with the rest of society more, settled people and homeless people should be able to mix socially more together as this would help to get rid of the stigma attached to homeless people as being nothing more than drunks and drug addicts"*

*"Homelessness comes under a myriad of guises from living on streets to whatever. More open - authorities to have a more open, understanding approach, rather than stereotyping."*

## 3.8 Spiritual well-being

Religion was identified as important to the majority of people (59%). In response to a question on factors that give meaning to life 23% of interviewees said that their children gave them a sense of meaning in their life (see Table 3.16). For 21% of people belief in God, prayer or spirituality was identified. Twelve percent of people couldn't identify anything that gave them meaning in their life.

Table 3.16: Sense of Meaning in Life

| Meaning in Life | No | % |
|---|---|---|
| Child(ren) | 15 | 23 |
| Belief in God / prayer | 10 | 15 |
| Nothing / don't know | 8 | 12 |
| Work / voluntary work | 6 | 9 |
| Plans for future / rebuilding life | 4 | 6 |
| Reflection / search for spirituality | 4 | 6 |
| Health | 4 | 6 |
| Family, friends, partner | 4 | 6 |
| Contact with others / meeting people | 3 | 5 |
| Being alive | 2 | 3 |
| Keeping busy | 2 | 3 |
| Hobbies / interests | 2 | 3 |
| Sense of values | 1 | 2 |
| Drink | 1 | 2 |
| Being sober | 1 | 2 |
| Being here (in house) | 1 | 2 |
| Having a home | 1 | 2 |
| Ordinary things | 1 | 2 |
| Feeling in control of life & taking care of self | 1 | 2 |
| When people are loving towards me | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

Table 3.17: Hopes for the Future

| | No | % |
|---|---|---|
| To have my own place / home | 21 | 32 |
| To get a job | 16 | 25 |
| To be in good health | 6 | 9 |
| To lead a normal life / stay stable | 5 | 8 |
| To have more contact with my child(ren) | 5 | 8 |
| To do /pass a course | 5 | 8 |
| To settle down / be settled | 4 | 6 |
| To be happy | 4 | 6 |
| To see my child(ren) happy | 4 | 6 |
| Being able to good for people / working to help others | 4 | 6 |
| Nothing / no hopes /don't know | 4 | 6 |
| To be recognised for something / feel part of something | 3 | 5 |
| To give up alcohol for good | 3 | 5 |
| To travel/ be able to save for holiday | 3 | 5 |
| To live a long life | 2 | 3 |
| Financial stability | 1 | 2 |
| To be secure | 1 | 2 |
| A better, more fair and more just society | 1 | 2 |
| To get stronger & find peace | 1 | 2 |
| To start a relationship & to love | 1 | 2 |
| To go to church | 1 | 2 |
| Singing | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

Figure 3.3 Satisfaction with living conditions

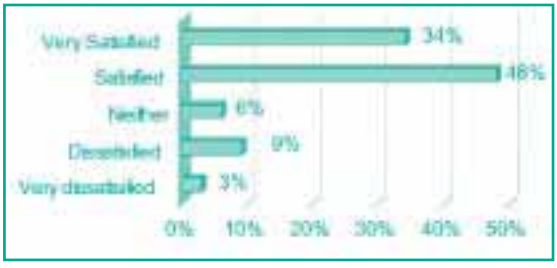



Table 3.17 shows the hopes interviewees had for the future. The main hopes expressed were for housing (32%) and employment (25%).

## 3.9 Living conditions / Environmental Well-being

### *3.9.1 Experience of living conditions*

The vast majority of interviewees (82%) were satisfied or very satisfied with their current living conditions (Figure 3.4).

The majority of people (68%) did not have concerns about their present living conditions. Of the 32 % that had concerns (Table 3.18), the main concerns

about living conditions were a desire to move on to one's own accommodation (8%) and disagreements of difficulties with other residents (8%).

Table 3.18: Concerns about where living conditions

| | No | % |
|---|---|---|
| Would like to move on | 5 | 8 |
| Disagreements / difficulties with other residents | 5 | 8 |
| Noise on the street | 2 | 3 |
| Concern for the future | 2 | 3 |
| Depressing atmosphere | 1 | 2 |
| People being turned away | 1 | 2 |
| Lack of social welfare assistance | 1 | 2 |
| Too many rules | 1 | 2 |
| Problems with landlady | 1 | 2 |
| Discrimination in neighbourhood | 1 | 2 |
| Concern about personal belongings | 1 | 2 |
| Condition of house – heating etc | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

Eighty six percent of people did not have feel that where they currently live affects their health (Table 3.19). Six percent of people stated that their current living conditions had a positive affect on their health. Fourteen percent identified negative effects on their health the most common being impact on mental health.

Table 3.19: Does where you live affect health

| | No. | % |
|---|---|---|
| Affects mental health (depressing / cause of stress) | 4 | 6 |
| Improves it | 1 | 2 |
| Comfortable, warm, food good | 1 | 2 |
| Encouraged to go to doctor | 1 | 2 |
| Keeps me off the drink | 1 | 2 |
| Can't socialise, don't know how to | 1 | 2 |
| Hasn't helped my health | 1 | 2 |
| 'Draughty - affect children's health' | 1 | 2 |
| Need to find confidence to say 'no' | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

The majority (82%) of people did not have concerns about their safety. Of those that had concerns (19%), the most common concern in relation safety was concern about a violent partner (Table 3.20)

Table 3.20: Concerns about safety

| | No. | % |
|---|---|---|
| Concerns about violent partner | 4 | 6 |
| When on streets | 3 | 5 |
| Mistrust of people on drugs / drink | 2 | 3 |
| Concerns at night | 2 | 3 |
| Assault / intimidated by neighbours | 1 | 2 |
| Suspicious | 1 | 2 |
| Fear of robbery | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

### 3.9.2 *Experience of sleeping rough*

The majority of people interviewed (71%) stated that in the past, they had no where to stay. Sixty percent of people described situations where they slept rough / outdoors. Sleeping rough was described as an extremely traumatic experience:

> *"Slept on streets, in warehouse. It was horrible. I could sit here all day and explain but I can't. Unless you have walked into hell you wouldn't understand. The most de-humanising experience I have ever had in my life. . . .Seen awful things young boys and girls of 14 prostituting themselves. Ripple effect families broke up."*

People slept out on the streets, in disused buildings and often anywhere they could:

> *"Slept rough on the streets . . . slept in a grave lined with cardboard, slept in a skip, slept in a barn, slept in a field covered with snow, had to dig a trench in the snow."*

Some people spoke of the impact of homelessness and sleeping rough on their mental health:

> *"No services for women, night shelter was only thing available for women. Stayed in Osterley Lodge, ware houses, friends houses. That effected mental health was drinking a lot at the time."*

Most people expressed feelings of fear and concerns for their safety when sleeping rough. Indeed several people had been assaulted and threatened:

> *"Terrifying is only word that I can sum that whole episode as."*

> *"Perished with the cold, alone on the streets, terrified it's an awful feeling not having a place to stay"*

> *"I had no where to stay, as I didn't*

*know anyone in London and had to spend a few nights sleeping rough in parks and on the streets of London. I was assaulted one night which was very scary."*

*"Fear was the worst part, one night I got threatened by a few junkies (heroin addicts) in Dublin because they wanted my blankets."*

Other feelings expressed included isolation, loneliness, worry, and feelings of depression and confusion:

*"The worst thing about sleeping rough is the sense of isolation."*

*"I never had to sleep rough on the streets but I had to stay in hostels. The loneliness and despair was the worst thing. "*

Day to day practicalities of keeping warm and dry; getting food and drink and washing cause stress when homeless. Difficulties of spending time during the day and getting to sleep at night add to the trauma:

*"It's amazing what you take for granted. Want to splash your face with water you have to sneak into McDonalds. Going to the tap and having a drink all the little things."*

*"I used to break into empty houses and stay there for the night. The worst thing was not being able to get a good nights sleep, and trying to keep dry from the rain."*

*"I slept in the stand of a football pitch . . . for 4 or 5 nights. . . . the freezing cold was also bad, I only every slept for half to one hour a night".*

One man encapsulates the impact of sleeping rough:

*"Being in prison was better than being on the streets. At least in prison there is some structure to daily activity and you are guaranteed a meal every day. Biggest fear in life to start drinking again and end up on the streets and eventually dying on the streets. Would rather die in prison than to freeze to death on the streets."*

Alcohol was identified in some cases as a cause of homelessness and also as a comfort when sleeping rough:

*"Many times I slept out drinking. Rough sleeping in doorways, derelict houses. Always had a drink problem."*

*"Drink is the only comfort you get on the street. Drink till you collapse and that's how you sleep."*

*"It (sleeping rough)'s tough and dangerous and that why you let yourself go back to the drink."*

The long-term impact of experiences, including the stigma of homelessness, was acknowledged:

*"I had to sleep out for 3 weeks until I got on my feet again. 20 years I was better then than I was now. It was distressing. I take it all on board, it's not easy"*

*"It was horrible not being able to wash, have to block out the way people look at you. Same shoes and socks. Priority to get back to work. Physically not warm, damp, not getting proper sleep. Bound to effect you somewhere (in the) future though wouldn't think it."*

### *3.9.3 Improvements to living conditions*

Interviewees were asked what would help to improve their living conditions. Responses are shown in Table 3.21. The majority identified a place of their own (34%) as the factor that would improve their living conditions. Twenty two percent of people said that they were satisfied with the way things are. Eleven percent of people said that getting a job would improve their living conditions. For many this meant independence and having a means to afford rent.

Table 3.21: Improvements to living conditions

| | No. | % |
|---|---|---|
| Moving on / getting own place | 22 | 34 |
| Satisfied with the way things are | 14 | 22 |
| Getting a job | 7 | 11 |
| Money to afford the things I need | 5 | 8 |
| Meeting some-one / having a friend to talk to | 3 | 5 |
| Relief from pain / worries about health | 2 | 3 |
| To be able to get on with life / independence | 2 | 3 |
| Hobbies | 2 | 3 |
| Entitlements | 1 | 2 |
| A plan for the future | 1 | 2 |
| Improvements to the house (heating, windows) | 1 | 2 |
| Present accommodation long term | 1 | 2 |
| Counselling | 1 | 2 |
| Less rules | 1 | 2 |
| A car | 1 | 2 |
| To keep busy and not think of problems | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

Some people raised specific difficulties in relation to housing and accommodation and highlighted the issue of housing need. Solutions offered to the housing issue included prioritising accommodation for homeless people, including single people; providing half way housing that promotes independence and providing follow up support once people move on:

> *"More chances or the homeless to get accommodation. You can phone every no. and get refused because they won't take rent allowances. A lot of people stuck here for months and have deposits from savings but won't sign rent allowance. A lot not listed as landlords, not paying taxes, defrauding"*

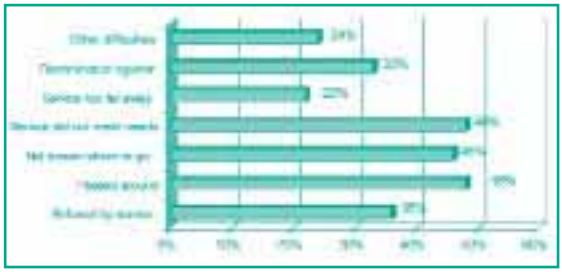
> *"Housing for people who have my problem or worse a half way house, but giving people independence not institutionalise, having areas of responsibility - make own sandwiches, do laundry like **** - small places like that are a good idea - big places are institutionalised and there's not enough hours in the day for staff."*

## 3.10 Services

### *3.10.1 Experiences of difficulties with services*

Interviewees were asked about difficulties that they may have experienced with services. The main difficulties identified in relation to services (Figure 3.5) were being passed around from one service to another (48%); feeling that a service did not meet their needs (48%); and not knowing where to go to get a service (46%). A third of people interviewed said that they felt they had been discriminated against when trying to use a service.

Figure 3.4 Difficulties with Services



Some interviewees gave examples of situations in which they had experienced the types of difficulties illustrated in Table 3.5. Discrimination was experienced due to age and the stigma attached to being homeless. Comments on services were made throughout the interviews and the main points are summarised here.

#### *City/ County Council / Corporation*

The main difficulties with corporation (now city council) / council services were in relation to entitlements and fairness and information on the process:

> *"Entitlements and corporation, saying that I am not entitled to this and that but others, others were given that option and rehoused but not me. Your rights after two years entitled to be re-housed elsewhere but they say you're not."*

> *"The whole accommodation scene was a big down fall for me. The corporation will not provide me with accommodation for 4/5 years on list. Then it's up to me to find my own accommodation and that leads to stress and depression and standard of accommodation is bad."*

#### *Health Board*

General points were made on equity in the health service

> *"Health is the most important thing*

*to everyone, but people can't pay for it. Government have to put a better system in"*

*"They should think of people on low income when devising health plans. There are a lot of things that homeless people can't afford to improve their health."*

The need for a non-judgemental approach within health services was also highlighted:

*"I feel that Health Board should be there to help people. People only go there for help and they should get that help and support and not be judged in anyway."*

Difficulties with mental health services were mainly in the area of respect, information and follow up care:

*"Follow up care from hospital not done very well. Doctor/ patient relations send you home with a load of pills and that's it. Poor communication between psychiatrists and GP's."*

*"Difficulties with Psychiatric services, I feel that I wasn't respected by them, they won't share information with me. I'm a person first, a patient second."*

In some cases, stigma associated with mental illness was seen to impact on use of services:

*"Because of the stigma it is difficult for parents of individuals to make the decision to consult a psychiatrist. The psychiatrist has been important to me."*

### *Welfare services*

Difficulties with community / social welfare were in relation to clothing grants and rent allowance, lack of clear information regarding entitlements and fairness:

*"The way welfare is set up not sure what they are there for except giving the cheque every week. Not enough information, not sure what you are entitled to."*

*"A lot of hostels wouldn't take you in unless you had money and have to have a formal address to get the dole."*

A number of people perceived that other sectors of the community receiving assistance while homeless people had greater difficulty receiving assistance:

*"I am not a racist and this is not a racist comment but refugees and asylum seekers are housed quicker and that's a fact. Two thirds of money from Europe. People say they get this and that moved on cos they are wanted to house refugees"*

### *Voluntary services*

Hostels and accommodation in Galway were compared favourably to hostels in other parts of the country. Many people referred to the positive relationships they had built with staff:

*". . . the most forward thinking in the country. Non-judgmental, amazing people, just totally relaxed."*

*"lovely staff here, nice to talk to they help in a big way."*

Difficulties with voluntary services were mainly in relation to access

### *Addiction treatment services*

Several people had used addiction treatment services – health, board and voluntary services and support groups. Experiences of services were mixed. A number of people found some services ineffective due to lack of expertise or suitability:

*"not doing anything to help people, left go with no money, no where to live, don't give a damn about people with addiction problems. I find this a disgrace. No interest in human being. . . . . Don't have doctors with expertise in addictions."*

A total of 34% reported having ever used addiction counselling services. A number of these people reported where they had used addiction counselling services (Table 3.22). The majority used the service in Merlin Park (12%) or Cuan Mhuire (6%)

Table 3.22: Addiction services

| Service | No | % |
|---|---|---|
| Merlin Park | 8 | 12 |
| Cuan Mhuire, Coolarne | 4 | 6 |
| Eastern HB | 1 | 2 |

| | | |
|---|---|---|
| Ballinasloe | 1 | 2 |
| Derry | 1 | 2 |
| AA | 1 | 2 |
| Total | 16 | 25 |

### *Education and literacy services*

A number of people reported difficulties with education and literacy services

> *"I tried I went to adult literacy classes and said they couldn't help me. OK reader it's spelling, pronouncing words (they) thought I needed another kind of help but I didn't."*

> *"Education I got stood for nothing pointless teaching kids skills that are no use to them.. . .Cruel teachers. Banging my head against the board over algebra. Didn't have the ability to pass on what they knew. School to me was a nightmare."*

The majority of people interviewed have medical cards. Fourteen percent of people experienced difficulties getting a medical card (Table 3.23). The main difficulties were getting a doctor to take them on their lists and not knowing where to go to apply for a medical card.

Table 3.23:Difficulties in getting a medical card

| | No. | % |
|---|---|---|
| Difficulty filling out forms | 3 | 5 |
| Difficulty getting a doctor to take on their list | 6 | 9 |
| Not knowing where to apply for a medical card | 6 | 9 |

* Multiple response, therefore percentages may not add up to 100%

Forty seven percent of people interviewed had missed a service or not attended a service when advised to. Services missed included AA, FAS, psychiatrist, counselling, addiction counselling, dole office, drop in centre, doctor, dentist, gardai, & social workers.

Reasons for not attending services were varied (table 3.24). Reasons included negative feelings (fear, shyness etc), feeling that service would not be helpful often due to past experiences and difficulties in relation to time and notification of appointments.

Table 3.24: Reasons for not attending services

| Reason | No. | % |
|---|---|---|
| Fear | 4 | 6 |
| Didn't feel like going | 5 | 8 |
| Past experiences unhelpful | 4 | 6 |
| Was drinking | 1 | 2 |
| Was depressed | 2 | 3 |
| Too shy | 1 | 2 |
| Didn't go at first have gone since | 2 | 3 |
| Manner of service provider | 1 | 2 |
| Felt unfairly treated | 1 | 2 |
| Lack of communication/ information between services | 1 | 2 |
| Hard to trust | 1 | 2 |
| Wasn't for me | 1 | 2 |
| Didn't think it would help / thought I was ok | 2 | 3 |
| Was somewhere else (work, hospital) | 3 | 5 |
| Letter sent to former address | 2 | 3 |
| Forgot time of appointment | 3 | 5 |
| Late notification of appointment | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

### *3.10.2 Improvements to services & additional services*

Interviewees were asked what would help to improve services and what additional services they would like to see in the area. The majority of (Table 3.25) were in relation to housing and accommodation. Requests for general improvement to services included a reduction in waiting lists and queues; respectful, non-judgemental services and advertisement of services. In relation to health services additional services for people with addictions were requested.

### *3.11.1 Smoking*

Eighty percent of people interviewed were current smokers. This is significantly higher than the national average of 27% (Slán, 2002). The amount of tobacco smoked per day is shown in Table 3.26.

Table 3.26: Amount smoked per day Tobacco/ cigarettes

| | No | % |
|---|---|---|
| 1-10 cigs | 17 | 26 |
| 11-20 cigs | 23 | 35 |
| 21-30 cigs | 5 | 8 |
| 31-40 cigs | 7 | 11 |

### *3.11.2 Alcohol or drug use*

The majority of interviewees (83%) reported ever drinking alcohol, that is 90% of men and 70% of women. A third of the men who drank said that they had given up for more than a month but used to drink heavily or had alcohol problems in the past.

Sixty two percent of people interviewed reported

Table 3.25 Improvements to / Additional services

| | | |
|---|---|---|
| **General Improvements to Services** | **15** | **23** |
| Reduce waiting lists / queues (Health & social welfare) | 3 | 5 |
| More caring system / respectful, non-judgemental services | 3 | 5 |
| Advertisement of information / services | 3 | 5 |
| Focus on street homeless | 2 | 3 |
| More confidential services | 1 | 2 |
| Understanding of the travelling community | 1 | 2 |
| Equity re- entitlements | 1 | 2 |
| Less abuse of services | 1 | 2 |
| **Housing / Accommodation** | **38** | **58** |
| More housing | 11 | 17 |
| More shelters / spaces | 9 | 14 |
| More accommodation for women and children | 6 | 9 |
| Better accommodation | 3 | 5 |
| Equity / fairness in allocating housing | 2 | 3 |
| Monitoring of landlords / Tenants rights | 3 | 5 |
| Accommodation services / help with accommodation grants | 2 | 3 |
| Longer opening hours of hostels /shelters | 1 | 2 |
| Help to ease transition from hostel to own home | 1 | 2 |
| **Health Services** | **18** | **28** |
| More services for people with addictions / Wet house | 5 | 8 |
| Improve mental health services | 2 | 3 |
| Half way house & psychiatric back-up | 2 | 3 |
| More health services | 2 | 3 |
| Improve access for homeless people to health services | 1 | 2 |
| Equity in health services | 1 | 2 |
| Improve child care services for children who have experienced abuse | 1 | 2 |
| Increased access to dental services for homeless people | 1 | 2 |
| More health services at weekend | 1 | 2 |
| Free health screening for homeless people | 1 | 2 |
| Health insurance (NHS) | **1** | 2 |
| **Social Welfare / Community Welfare** | **6** | **9** |
| Better social welfare / increase in payments to assist with deposits | 3 | 5 |
| Less bureaucracy in social welfare | 1 | 2 |
| Treat homeless people independent of other welfare recipients | 1 | 2 |
| Longer opening hours (Social welfare, CWO) | 1 | 2 |
| **Other Services** | **14** | **22** |
| Reasonable childcare / crèche | 3 | 5 |
| Parent / toddler groups | 1 | 2 |
| More help from guards & social services | 1 | 2 |
| Better transport | 2 | 3 |
| Job seeking services | 1 | 2 |
| More courses | 1 | 2 |
| More residential care | 1 | 2 |
| Men's rights / support for separated men | 1 | 2 |
| Improved services for older people | 1 | 2 |
| Allowance for sports in gym | 1 | 2 |
| **Voluntary Services** | **4** | **6** |
| Increase funding to voluntary services | 2 | 3 |
| More Samaritans | 1 | 2 |
| Improve rape crisis centre (education for staff) | 1 | 2 |

Table 3.25 contd.

| Specific Services for Homeless People | 13 | 20 |
|---|---|---|
| Drop in / day centres | 6 | 9 |
| More homeless services | 3 | 5 |
| Free phone lines / helplines for homeless people | 2 | 3 |
| Regular AA meetings in the Fairgreen | 1 | 2 |
| Allocated social workers for homeless people | 1 | 2 |

alcohol consumption in the last month, that is 60% of men and 65% of women. The numbers of units consumed per week are shown in Table 3.27. The levels of alcohol use were extremely high among current drinkers with 48% of men, who had reported drinking in the last month, drinking over the recommended level of 21 units a week and 20% of women, who had reported drinking in the last month, drinking over the recommended level of 14 units a week. Excessive levels were reported with a number of people reporting over 200 units a week. Some people did not report the amount they consumed but gave comments such as 'as much as I can', others said that they drank more heavily in the past. A third of all people interviewed reported that they had received alcohol counselling.

Table 3.27: Units of Alcohol

| Units per week | No. | % of current drinkers |
|---|---|---|
| 0-21 | 19 | 48 |
| 22-40 | 5 | 13 |
| 41-60 | 1 | 3 |
| 61-80 | 2 | 5 |
| >81 | 4 | 10 |
| Total | 31 | |

The CAGE Questionnaire is an alcoholism screening instrument. (NIAAA, 2002). A total score of 2 or greater is considered clinically significant. The CAGE questionnaire was carried out only with those interviewees who were current drinkers or who had given up alcohol within the last month, a total of 40 people (2 people did not participate). Fifty five percent of current drinkers scored 2 or greater indicating alcohol problems.

Table 3.28: CAGE Questionnaire

| CAGE Score | No. |
|---|---|
| Score | |
| 0 | 9 |
| 1 | 8 |
| 2 | 6 |
| 3 | 2 |
| 4 | 13 |
| Total | 38 |

The Drug Abuse Screening Test (DAST – 10) is a screening tool for drugs other than alcohol (Addiction research foundation, 1982). A score of 1-2 indicates low level of problems related to drug abuse; 3-5 indicates moderate level warranting further investigation; and 6-8 indicates a substantial level of problems related to drug abuse requiring intensive assessment.

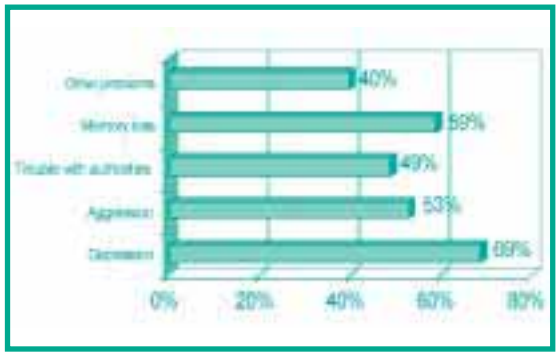
Forty two percent of people interviewed who had used drugs scored 1-2 indicating low level of problems; 24% scored 3-5 or moderate level problems. Thirty five percent of people who had used drugs scored over 6 indicating need for intensive assessment.

Table 3.29: DAST Questionnaire

| DAST Score | No. | % |
|---|---|---|
| Score | | |
| 1 | 7 | 27 |
| 2 | 6 | 15 |
| 3 | 5 | 12 |
| 4 | 3 | 8 |
| 5 | 2 | 4 |
| 6 | 0 | 0 |
| 7 | 5 | 12 |
| 8 | 2 | 4 |
| 9 | 8 | 19 |
| Total | 26 | |

Of those who are current drinkers, or who have used drugs 69% have experienced depression as a result of their substance use. Fifty nine percent have experienced memory loss; 53% have experienced aggression and 49% have experienced trouble with the authorities

Figure 3.5: Problems with Drinking or Drug Use



### 3.11.3 Experiences of Addiction

Addiction was a problem for many interviewees. Addiction and the downward spiral into homelessness were described. The stigma associated with addiction compounded the negative experience:

> *"Begging on the street to keep habit going. Squatted in a lot of places in London. Nothing matters only next fix. What ever you can think of and add one thousand percent it's that bad . . . . Serious lack of understanding (about drug problems) nice to avoid own problems by throwing you into a compartment "look at _____ a junkie".*

> *"Came to live in Galway but spent all my money on drink and drugs and could not afford to pay rent anywhere."*

Precipitating factors were not always described, but many associated alcohol and substance abuse with their response to traumatic life events such as bereavement, difficulties in childhood, relationship difficulties.

Alcohol and substance use was used as a coping mechanism and as a comfort. Alcohol was a means of socialising and combating loneliness. This was often the case for people who had experienced emigration:

> *"I just blank them (problems) with drink but things are 3 times worse than usual."*

> *"On the dry for a couple of weeks. Valium and sleeping tablets in England and drinking"*

Excessive drinking often started in youth. Alcohol problems were common and the impact on personal lives included relationship, financial and work-related problems:

> *"Due to previous drinking, my family don't want anything to do with me."*

> *"I lost a lot of friends people didn't want to talk to me or even drink with me."*

> *"Had drink problem since a young lad. Poitin in Connemara. Hundreds of jobs lost then through drink. Drink at lunch and then lost jobs."*

Alcohol use and addiction was also linked to low self-esteem, low self-confidence and mental health problems:

> *"My confidence took a battling on the drink."*

> *"Support especially in here ***** trying to help and nurse in *****. Apologise for being alive and self esteem . . now it's not you. It can happen to any one. People look at you as if you are not trying and that's not true. Maybe I deserve this mad notion."*

> *"When drinking often had no where to sleep 'anywhere at all' You don't realise these things when your drinking feeling suicidal. Went to Unit . . . then realised drink was a major contribution."*

In many cases their addiction was identified as the reason for becoming homeless. Drink was also used as a solace when homeless and an aid to passing the day, getting to sleep and coping with the stress of being homeless. Many participants had given up alcohol and spoke of the struggle to stay sober. Fear of relapse was common. The use of treatment service was frequently referred to. Some people highlighted the need for alternative support and coping mechanisms:

> *"Group meetings so people can say how they feel and can let off steam if they need to. Not talking about problems leads to drinking"*

> *"Organised group discussion with other alcoholics. One to one confidential meetings would be great. It's good to talk to people and share your worries with them."*

> *"Trying to stay off the drink it's difficult to socialise, cause that's where the crowd I know socialise in the pub or with drink"*

One person summed up the experience of alcoholism and homelessness:

> *"Alcoholics do not choose to live on*

*the street, but their craving for drink is so strong they can't help themselves and end up drinking and getting drunk and then they are not allowed to stay anywhere but the streets. When you're an alcoholic, drink is the true love of your life. It comes before family and friends. Drinking culture seems to be accepted in Ireland and this is the root cause to most alcoholics"*

### *3.11.4 Diet*

A total of 41% of people interviewed had concerns about their diet. The main concerns (Table 3.30) were in relation to diet were decreased appetite or not eating enough (8%) and a need to reduce sugar intake (8%).

Table 3.30: Concerns with diet

| Do you have concerns about you diet ? | No. | % |
|---|---|---|
| Decreased appetite /Don't eat enough | 5 | 8 |
| Need to reduce sugar | 4 | 6 |
| Want to lose weight | 3 | 5 |
| Need more fruit | 3 | 5 |
| Too much fatty foods | 2 | 3 |
| Not eating healthily | 2 | 3 |
| Not enough variety | 1 | 2 |
| Can't find food I like | 1 | 2 |
| Not enough time to eat | 1 | 2 |
| More vegetables | 1 | 2 |
| Less salt | 1 | 2 |
| Diabetic diet | 1 | 2 |
| Stomach problem | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

### *3.11.5 Physical Activity*

Levels of physical activity were high among people interviewed. These are compared in Table 3.6 with levels in the Irish general public as reported in the SLáN survey (Friel, 2002). A total of 43% of people interviewed reported doing moderate activity at least three times a week compared to 22% in the SLáN survey. A total of 39% of homeless people engaged in mild activity at least four times a week, compared to 32% of the general public. Levels of strenuous exercise were lower among the homeless population with no people engaging in this level for a least three times a week compared with 11% of the general public.

Figure 3.6: Levels of Physical Activity


## 3.12 Information

### *3.12.1 Access to information*

Sixty one percent of people interviewed did not have enough information on out of hours services. Thirty seven percent of people did not have enough information on entitlements. A third of people did not have enough information on health services and a third did not have enough information on other services. Thirty percent of people did not have enough health information. Difficulties getting information were varied and included difficulties in relation to accessibility of information and availability of user friendly information (Table 3.31).

Table 3.31: Difficulty getting information

| | No. | % |
|---|---|---|
| Wouldn't know where to go | 1 | 2 |
| Like to know more about drug addiction | 1 | 2 |
| No access to a phone | 1 | 2 |
| Difficulty reading & writing | 1 | 2 |
| Conflicting information on entitlements (corporation & welfare) | 1 | 2 |
| Not knowing where to or how to complain about care | 1 | 2 |
| Difficulty getting information on legal status | 1 | 2 |
| Results of blood test not understood | 1 | 2 |
| Psychiatric services not sharing information | 1 | 2 |
| Difficult to get information about separation & legal aid | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

Sixty four percent of people interviewed said that more information would be helpful to them. The greatest information need was information on entitlements (Table 3.32).

Table 3.32: Further information

| What would you like more information on? | No. | % |
|---|---|---|
| Entitlements | 13 | 20 |
| Medical / Health information | 5 | 8 |
| Services for homeless people | 3 | 5 |
| Housing / accommodation | 3 | 5 |
| Everything / general information | 3 | 5 |
| Disability information / entitlements | 2 | 3 |
| Getting a job | 3 | 5 |
| Rights / Laws | 3 | 5 |
| Other | 7 | 11 |

* Multiple response, therefore percentages may not add up to 100%

The best ways of getting information to people were identified as through staff, citizen's information centres, social welfare or through posters of leaflets in houses and hostels (See table 3.33)

Table 3.33: Information sources

| What is the best way to get that information to you? | No. | % |
|---|---|---|
| Staff in hostels / houses | 11 | 17 |
| Citizen's Advice / CIC | 6 | 9 |
| Social welfare | 6 | 9 |
| Posters / leaflets in houses / hostels | 6 | 9 |
| Information office / day centre | 3 | 5 |
| By post | 5 | 8 |
| GP | 2 | 3 |
| Posters/ leaflets in services | 3 | 5 |
| All agencies | 2 | 3 |
| CWO | 1 | 2 |
| Health service, Newcastle Rd | 1 | 2 |
| Nurse in day centre (currently attending) | 1 | 2 |
| Galway Youth Diocesan Service | 1 | 2 |
| Threshold | 1 | 2 |
| Disability workers | 1 | 2 |
| Other people | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

### *3.12.2 Literacy*

Fourteen percent of people interviewed had difficulty with reading, 19% had difficulty with writing. Of those who expressed difficulty with reading and writing 29% said that they would like help with reading or writing.

Table 3.34: Literacy

| Literacy | Yes | % | No | % |
|---|---|---|---|---|
| Difficulty with reading | 9 | 14 | 56 | 86 |
| Difficulty with writing | 12 | 18 | 53 | 82 |
| Would you like help with reading or writing? | 6 | | 11 | |

## 3.13 Health Promotion Plan

### *3.13.1 Quality of Life*

Interviewees were asked what would help to improve their quality of life. The majority of suggestions were own housing/ good accommodation (42%) and getting a job (28%).

Table 3.35: What would help to improve your Quality of Life

| | No. | % |
|---|---|---|
| Own place/ house/ apartment | 24 | 37 |
| Good accommodation | 2 | 3 |
| Help with getting a house | 1 | 2 |
| A job | 18 | 28 |
| More money | 7 | 11 |
| Company/ friends | 5 | 8 |
| More time/contact with child(ren) | 4 | 6 |
| Help for my child(ren) | 2 | 3 |
| Childcare | 2 | 3 |
| Socialise more | 3 | 5 |
| A relationship | 2 | 3 |
| Improved health | 3 | 5 |
| A hobby | 3 | 5 |
| Help with further education | 3 | 5 |
| Independence | 3 | 5 |
| Staying off alcohol | 2 | 3 |
| Counselling | 2 | 3 |
| Self confidence / being happy inside | 2 | 3 |
| More support | 1 | 2 |
| Help with spelling | 1 | 2 |
| Separation | 1 | 2 |
| Citizenship | 1 | 2 |

* Multiple response, therefore percentages may not add up to 100%

In addition some interviewees spoke of their desire to rebuild their lives and overcome their difficulties:

> ***"My slogan is HALT I use this philosophy everyday I will never let myself go Hungry, Angry, Lonely or Tired. I will try never to let HALT take over, but sometimes it is very hard."***

The importance of prevention in relation to homelessness was emphasised:

> ***"There is more care required. Prevention of homelessness is what really needs to be looked into. It's a vicious circle – so many factors involved."***

### *3.13.2 Health Promotion priorities*

Interviewees were asked an open ended question on what should be included in a plan to promote their health and the health of other people in a similar position (see table 3.36). The majority of suggestions were in relation to health-promoting services, including increased funding for health services, equity in relation to government spending; additional and improved accommodation and a day centre. Drug education for young people and information on entitlements for homeless people were among health education suggestions and suggested programmes included an exercise programme and one to one counselling.

In addition to the open ended question, interviewees were given a list of possible measures to promote the health and wellbeing of homeless people in the

Table 3.36: Health Promotion Plan

| | No. | % |
|---|---|---|
| **Health Education / Information** | **7** | **11** |
| Drug / alcohol education for young people | 2 | 3 |
| Health education for homeless people | 1 | 2 |
| Visible, accessible information | 1 | 2 |
| Information on rights / benefits for homeless people | 2 | 3 |
| Information on help for homeless people | 1 | 2 |
| **Programmes** | **10** | **15** |
| Exercise programme | 2 | 3 |
| Alternatives to alcohol e.g. sport | 1 | 2 |
| How to cope with addiction | 1 | 2 |
| One to one counselling | 2 | 3 |
| Focus on mental health | 1 | 2 |
| Meditation / relaxation | 1 | 2 |
| Support groups for women | 1 | 2 |
| Group meetings | 1 | 2 |
| **Health - Promoting Services** | **28** | **43** |
| Funding for a better health system / address inequity in government funding | 3 | 5 |
| More & better accommodation (incl. emergency) | 3 | 5 |
| More chances for homeless people to get accommodation | 2 | 3 |
| Address discrimination / ill treatment of homeless people | 2 | 3 |
| Day centre | 3 | 5 |
| More services for homeless people | 2 | 3 |
| Community-based courses / education | 2 | 3 |
| Information on health board complaint procedure | 1 | 2 |
| Review addiction treatment services | 1 | 2 |
| Open, understanding approach in agencies | 1 | 2 |
| More staff in Fairgreen | 1 | 2 |
| Mixed hostels with sections for short, medium, long term | 1 | 2 |
| More health service staff for people sleeping out | 1 | 2 |
| Help for single people | 1 | 2 |
| Needs of women & children experiencing separation / violence & abuse | 1 | 2 |
| Financial support | 1 | 2 |
| Child care facilities | 1 | 2 |
| Soup run | 1 | 2 |
| **Health-Promoting Mental Health Services** | **5** | **8** |
| Better access to psychiatry | 1 | 2 |
| Improve mental health services- early diagnosis & decrease suicide rates | 1 | 2 |
| Follow up care from hospital- communication between psychiatrist & GP | 1 | 2 |
| Improve doctor – patient relationships (psychiatry) | 1 | 2 |
| Half way house | **1** | 2 |

* Multiple response, therefore percentages may not add up to 100%

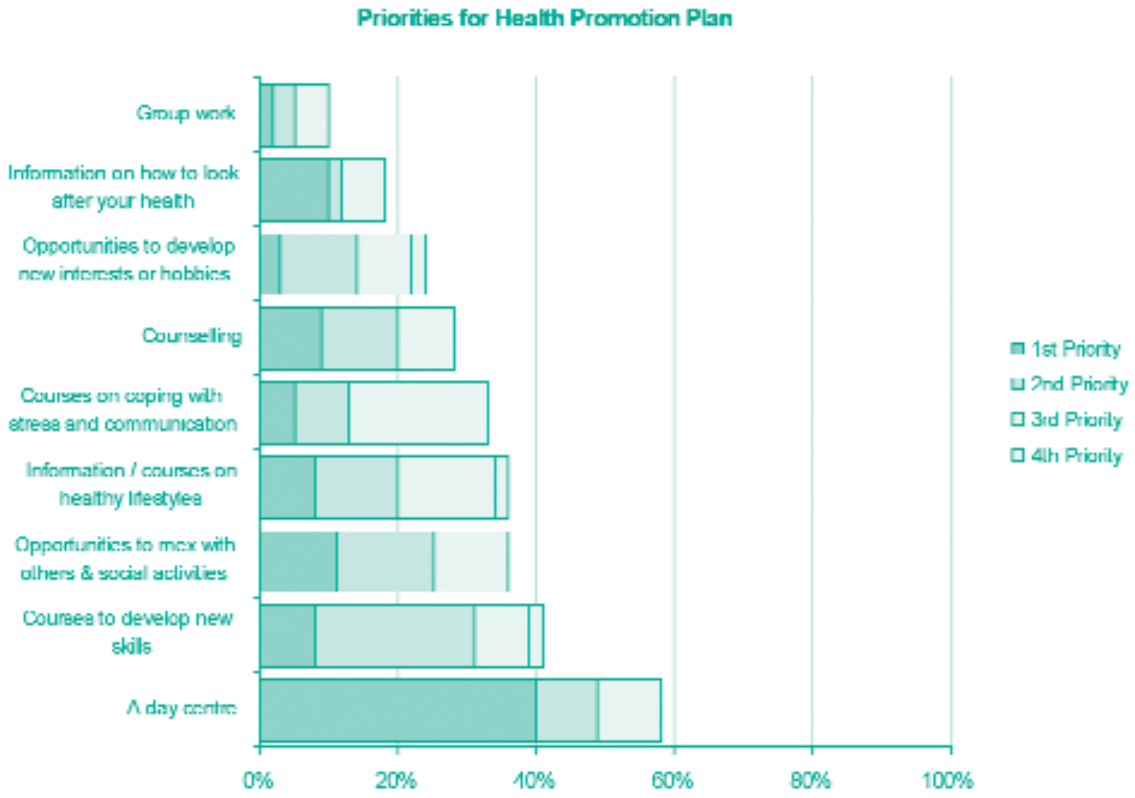



Figure 3.7 Health Promotion Priorities

area (Figure 3.10). A day centre was rated highest overall (58%) and highest first priority (40%).

Twenty three percent of people interviewed identified courses to develop new skills as second priority, with 14 % choosing counselling as second priority.

# Chapter 4 – Focus Group

# 4. Focus Group Analysis

## 4.1 Introduction

Three focus groups were carried out with service providers in the Western Health Board region. Participants were representative of statutory and voluntary agencies who provide services to homeless people in the region. Front-line staff, who work directly with homeless people, were involved in the focus groups.

Focus group participants were asked to reflect on their experiences of working with homeless people to create discussion on issues relating to homelessness and homeless people in the region. The following results represent a summary and interpretation of the three focus groups attended by service providers. A total of 17 individuals participated in the focus groups. Twelve organisations were represented.

## 4.2 Health Status of Homeless People

### *4.2.1 General Health*

The health and well-being of homeless people was generally described as poor. Homeless people presented with a myriad of health problems. Physical health problems, especially bronchial problems and infections, were associated with their homeless situation and exposure to the environment. The homeless lifestyle, including poor diet, and lack of facilities also contributed to ill health especially lack of cooking facilities or affordable healthy food options:

> *"'I've seen a great many health problems with homeless people which would range from drug and alcohol abuse and also under that misconception that alcohol would keep you warm at night if you were sleeping rough and of course you're not going to eat because you've started drinking first thing in the morning so there's no appetite, to problems, cardiac problems, circulation problems, diabetes, foot problems, chill burns. I've see frost bite you know and all sorts of problems because you can't get adequate clothing, you can't get decent shoes, the shoes that people are getting are second hand so they don't fit them properly and they're walking around for hours, all night and . . . as well mental health problems"*

In one of the focus groups participants described an improvement in the health of homeless people who had received support services. This was compared favourably with their health status when they first accessed services.

Health was seen as low in terms of priority for homeless people. Practical issues and day-to-day worries such as securing a place to stay for the night, getting food, having enough money to survive took priority over health. Some participants felt that homeless people were not able to look after themselves properly due to addiction problems or other issues.

### *4.2.2 Addiction*

Poor health and neglect of health was also associated with addiction. A number of participants gave examples of poor diet and general neglect with people abusing alcohol.

Alcohol addiction was reported as most common, but also drug addiction including addiction to prescription medication. Several participants mentioned that addiction did not necessarily occur in isolation and was associated with problems such as violence, abuse, relationship difficulties and mental health problems.

Loss associated with addiction, in particular addiction to alcohol, included loss of contact with family due to behaviour. Addiction also made it difficult to break the cycle of homelessness.

### *4.2.3 Mental Health*

Mental health problems were seen as very common among the homeless population, especially depression, schizophrenia, anxiety and panic attacks. Several participants highlighted how difficult it is for people to cope with mental health problems in addition to being homeless. Alcohol problems and mental illness were linked by some participants. One participant gave an example of people using alcohol to mask the symptoms of schizophrenia.

### *4.2.4 Violence and abuse*

Many participants spoke of problems which stemmed from violence and abuse. Many homeless people had experienced or witnessed some form of abuse, from alcohol abuse in their families to mental, physical, emotional or sexual abuse. The impact of violence and abuse leading to low self esteem and often relationship difficulties, mental

health problems, addiction and other problems:

> *"I think many of them really, they were abused generally, which consequently may lead to the addiction . . . the abuse then that's never been acknowledged, number one, you know maybe we might be the first people they have disclosed it to and that could be twenty years later, again then there's no support for them so they've had to leave the home maybe that they were in because of this or sexual or whatever kind of abuse and they're that's how they find themselves being homeless because it's not safe for them to be at home, they don't have the contact with their family any more or maybe with one or two family members, essentially they had to isolate themselves to be safe and you'll also find, you know, they left home as a teenager, they've gone into care, they then leave that care they're still unable to cope, they don't have the skills. But it all comes from the abuse which has never been disclosed or acknowledged."*

> *"A lot of people that I've worked with have experienced or witnessed one abuse or another, and certainly there's been a lack of affirmation for a lot of people that I've worked with as children which leads on to self esteem issues, they may have witnessed alcohol abuse in their families and this has the knock-on effect you know, it doesn't particularly matter what sort of abuse it has been, mental physical emotional, sexual or lack of affirmation, . . . and this has created a repeat pattern at times you know there is a lack of self esteem . . . Often times themselves this is leading on to mental health problems or alcohol and addiction problems and this feeling of not quite fitting in"*

Participants stated that most women accessing services were in that position because they were experiencing domestic violence. A number of participants identified a lack of expertise or awareness within main stream services to address underlying abuse. One participant highlighted the example of women being treated for alcoholism and depression who had been victims of domestic violence for years. Traveller women, homeless as a result of violence and abuse were described as being particularly vulnerable and faced additional barriers in accessing alternate accomodation. I some cases this resulted in women returning to the home where violence occured. Gaps in services for women and children who have experienced domestic violence were highlighted. In particular counselling and accommodation services, including move on and transitional accommodation:

> *"In the long term we would find that women will go back to their home if they cannot get any accommodation so that they're being forced in a way to go back an abusive situation . . . if you've got supported transitional homes. It's not just a housing thing it's about working with them, working with the impact that homelessness has had on them maybe or the violence has had on them or the addiction has had on them."*

### 4.2.5 Stress

Participants highlighted the main stresses experienced by homeless people. The main stresses were the homeless situation, poverty and lack of access to services. Participants described the daily stress and insecurity of finding somewhere to sleep and somewhere to put belongings. Poverty means that homeless people are surviving from day to day and don't have choices available to them. Practicalities in relation to access services were detailed. Not having a fixed address, people risked missing out on services they are entitled to. Some felt that once people had accessed accommodation and support services such stress was reduced. Others highlighted lack of follow up care and the associated stress. Attitudes towards homeless people were identified as another cause of stress. Participants reported that homeless people felt that people don't listen to them and spoke of a difficulty in expressing themselves to people who are seen in more powerful positions. Feelings of anger, frustration, loneliness, boredom and isolation were described.

### 4.2.6 Self esteem

Low self esteem was seen by many participants as a key factor in the situation of homelessness.

> *"Being homeless I think takes a huge toll on someone's self esteem an absolutely massive toll, and that then affects everything, you know your ability to form other ordinary*

*relationships and to feel valued and feel part of things, which is going to affect your mental health and so I think self esteem issues are massive"*

The impact of homelessness on one's self esteem was discussed. This was associated with the trauma and insecurity of homelessness, as well as the despair associated with a lack of prospect of their situation improving. Low self esteem was seen to impact on people's confidence to seek support or to get in contact with services:

*"when you go a bit deeper, their self-esteem and their confidence is just so low. They would have been in care and almost all their lives, and then when they came out of care they just didn't have the support services there. Maybe got married young, got in with a partner, wasn't so good to them and all that you know, maybe violent partner. And the whole thing it can just be down, down, down, and all of a sudden they're so low and it's just trying to get them up again just to, even get them to link with services, you know to be able to have the confidence to come in the door and just talk to somebody."*

Lack of self esteem was also related to the past experiences of homeless people. Difficulties such as relationship problems, domestic violence, lack of acceptance, being in care, mental health problems, alcohol or drug abuse were seen as contributing to low self esteem and lack of confidence.

### 4.2.7 Social well-being and Relationships

Relationships and social well-being were discussed at length in each of the focus groups. Most homeless people had poor social supports leading to feelings of loneliness and isolation. Many had lost contact with family members. Various reasons were given for loss of contact and break down in family relationships, including problems with family of origin, violence and abuse, being in care or institutions, emigration, problems due to their past behaviour and addictions, and lack of acceptance by family of mental health problems.

Lack of social contact and support from family or friends was seen as a factor in people becoming homeless. Participants felt that in some cases homelessness could have been avoided if further social and emotional support was available.

Difficulties in maintaining relationships or building new relationships were also associated with lack of social skills and problems with trust, as a result of past experiences.

### 4.2.8 Women's Health / Men's Health

Different issues were presented in relation to health of women and men. It was reported that men did not tend to use primary health services, such as GP services and were seen to neglect their health. Alcohol addiction was reported as more common amongst men.

Whereas women accessed services to a greater degree, lack of information or compliance in relation to medication, for example finishing courses of antibiotics, was reported. Some participants felt that women were over-prescribed prescription medication. Access to smears, sexual health, contraception and support in relation to domestic violence were highlighted as priorities for women's health.

### 4.2.9 Sexual Health

Sexual health and risk of sexually transmitted diseases was identified as a cause of concern in two of the focus groups, especially for people who had experienced sexual abuse or those working in prostitution. Woman who had experienced sexual abuse were seen as at risk of repeated abuse and a cycle of promiscuity and abuse. The potential for targeted sexual health promotion campaigns was discussed. One participant spoke of women who had experienced abuse engaging in risky behaviour or being at risk of repeated abuse and highlighted the need for follow on support for people who have experienced abuse:

*"Where they have experienced sexual abuse and they're in that whole cycle and not able to get out of it so they're continually putting themselves at risk and not able to access services . So for instance you can refer a women to a counsellor where she can actually maybe disclose some of the abuse she has experienced but because there is no follow-on support for them . . . it breaks down very quickly then again and again they're back into the cycle of, you know, being abused"*

### 4.2.10 Health of Children

The health of homeless children was mentioned in two of the focus groups. Most referred to situations where a woman with a child or children experienced homelessness. Concern was expressed over the

fact that homeless children were exposed to the same environmental and lifestyle difficulties as their parents. Some of the children would also have suffered the impact of problems in the home and domestic violence. Young children who had experienced homelessness were seen to miss out on social interaction and education. There was also a concern that they were missing out on services normally provided to young children and therefore problems cannot be detected. Support needs of parents were highlighted.

### 4.3 Experiences of Homelessness

Participants related the trauma of homelessness as experienced by their clients. The homeless lifestyle was described as chaotic and unstable. People accessing services found it difficult to maintain stability in their lives. Homelessness was associated with poverty and unemployment. For most women and children, in particular, homelessness was as a result of domestic violence and abuse. Some people spoke of a sense of hopelessness experienced by homeless people. The stigma associated with homelessness was described. One participant spoke of unprovoked assaults of homeless people. The impact of the stigma and discrimination left people vulnerable and degraded. The causes of homelessness described included mental health problems, domestic violence, abuse, relationship break up, unstable family backgrounds, addiction problems, lack of safe affordable housing, poverty resulting in eviction, leaving institutional care, lack of integration on return from emigration and lack of social support. In many causes many factors were involved.

Homelessness was described as a cycle. 'Cycles' were referred to by many participants – a cycle of recurring homelessness; a cycle of abuse; a cycle of generational homelessness; a cycle of institutional care; a cycle of homelessness on discharge from psychiatric care or addiction treatment without anywhere to go; a cycle of addiction; a cycle of lack of housing, health problems, low self esteem, poverty, unemployment, relationship problems and homelessness. In one of the focus groups the strengths and resilience of homeless people were described as well as the frustration in cases when things do not work out for people trying to rebuild their lives.

### 4.4 Accommodation and Housing

Accommodation and housing were key themes in each of the focus groups. Housing need was stressed and it was described as a crisis. Examples of lack of housing and substandard housing were given:

> ***". . . there's less and less accommodation for single people who are claiming benefits for example, and it also means any accommodation they do get is full of damp and disrepair and then there is another physical health problem through that, do you know, whether that's for single homeless people or for single parents, you know, certainly the risk to children in terms of damp as well as the elderly particularly is desperate you know, inadequate heating, are they safe in terms of banisters and windows and this that and the other, the risk of those kind of problems from damp and disrepair, risk from electrocution, risk from falling, accidents, it's desperate."***

The impact of the housing problem was discussed. One of the difficulties for support agencies is the lack of decent affordable housing when service users are ready to 'move on'. Other problems in relation to housing were discrimination by landlords, abuse of tenants rights and other tenancy issues:

> ***"And even when there are controls like, like you have a months notice before you can get put out. Show me a homeless person is actually is aware of that or who actually has confidence to say I'm not leaving because my rights are that, they don't see that they have any rights, because in fact they don't have any rights, and they know well that they'll be put out, and once they are on the streets, they've lost it, that's it. And that's what happens all the time, so, so, more often than not, if somebody's messed up for one reason or another, I mean, they're out, at the end of the week or they're out that day."***

A need for housing policy to address homelessness was identified. Solutions to the housing crisis included legislation. Most participants agreed that current legislation needs to be enforced. This included legislation on adaptable housing for disability, landlord and tenant law, standards and rent regulations. Some participants suggested that people should have clear information on their rights as tenants and that landlords should accept tenants who are on rent receipts. A register of landlords who accept rent allowance was suggested. The

importance of inspections of accommodation standards was stressed. The development of housing associations was welcomed. Security of tenure was seen as a priority:

> *"if they had the legislation, maybe around security of tenure, that you know, you can't just get kicked out by for any old reason or that they enforce that the landlords have to give notice to quit, and they can't just come in and change the locks and say 'oh I'll see you in court' and then you have people who are homeless at that stage, or else a social welfare payments. And of course they're not going to see them in court because they don't have the facilities to go there, or the money. Or if they're on rent supplement that landlords will take it, or that you force landlords to be registered, there's so many things, if the legislation was enforced you would have more security of tenure, you'd have better quality accommodation, you'd have less people becoming homeless and remaining homeless"*

> *"But I think taking it right back to source in terms of the fact that housing is never ever on the political agenda, never was apart from owner occupation, which means there's a lack of safe, affordable accommodation. Which means more and more people are at risk of becoming homeless"*

The need for supportive housing and move on accommodation was highlighted in two of the focus groups:

> *". . . we are raising those peoples anxieties in some cases unfairly because there isn't then enough decent affordable housing for them to move on into so, you know, that is definitely an issue again around peoples mental health and well being that if there was more decent quality move-on accommodation that people could move on to and still be supported by organisations like ourselves, would link in again with the other services that are needed, CWO's, GP's, psychiatric services, etcetera, etcetera. That's going to lower peoples anxieties hugely and promote well being if you actually, if those services are available."*

Some frustrations were expressed with attempts to improve the housing situation. One of the difficulties put forward was that penalising landlords might take some of the more affordable accommodation of the market.

## 4.5 Services for Homeless People

### *4.5.1 Access to services*

Access to services was considered an issue for homeless people. In some cases services, such as medical cards, could not be accessed without a fixed address:

> *"If you're always at a different address it's really difficult to, you know to, you might lose out on your position on a housing list because you haven't kept them informed, you might miss out on payments from your social security, you might not be able to get a GP at all, no one might take you on, you know just all these things that we take for granted."*

Some participants felt that services were not provided because of one's homeless status, for example some homeless people had difficulty getting onto GP lists. Other access issues were in relation to transport.

> *"but you have to walk to somewhere, is there somewhere that you could have just all the services in one, like the city centre, where all the buses go to the city centre, you know, that you're not going to one hospital for one thing and over to Merlin Park for another and out to Mervue for another, you know, like really when they're homeless and do you have the energy to be going…"*

Several participants commented that some homeless people did not link in with or access services. Examples were given of situations where appointments were not kept. Various reasons were offered for not using services including difficulties in keeping appointments due to lack of structure, low self esteem and fear:

> *". . . their self esteem is so low that they don't even have the confidence to*

*link in with services. If you go with them, if you come with them, maybe. But if you leave them to link it on their own, they won't and they'll say they couldn't go and they'll make excuses, I kind have now got the idea that their, they just have, their self esteem is so low that they're just not able to go in now. . . . (One woman) she was just terrified she could go back into a psychiatric hospital again. But actually it was the best thing to happen you know, that she was put back because she needed care and she needed psychiatric help and she needed to be on medication. She wasn't on anything and she was wandering the streets and she wouldn't link up with anybody you know. And she's much better now"*

Another reason for not accessing services was that health was seen as low in terms of priority for homeless people in comparison with finding accommodation and having enough food to eat. Men in particular were seen not to access services. A number of participants felt that people did not have enough information on where services are available.

One participant gave examples of difficulties in providing follow up and services such as child development check ups when people move on and don't leave a new address.

### 4.5.2 Attitudes and Approaches within services

Several participants across all focus groups commented on attitudes within services. It was seen that attitudes varied and depended on individuals within services, especially Corporation, Health Board and GP services. It was stated that some individuals within services displayed negative attitudes and lack of understanding or empathy towards homeless people. A lack of awareness in relation to domestic violence and disability issues was also highlighted. A need for training within statutory services was identified, training on the 'whole area of homelessness' and on treating homeless people in a sensitive manner.

*"It's statutory agencies in general, that aren't probably given training, you know, there's an assumption that it is covered by voluntary agencies, that that's the end it comes from. And not everybody had the same attitude either, but I suppose it's unfair if people are put in a job and they're not actually not getting training for it."*

Some participants felt that there should be joint training with voluntary and statutory agencies learning about each other's service.

Gaps in services were identified including lack of community-based services and lack of follow up. Follow up was seen as important for people leaving care or support services. Examples included leaving care, psychiatric, general hospital and addiction treatment services.

While greater flexibility was identified as a need within services, some comments were made on a more accommodating approach within services in Galway in comparison with larger urban centres. For example, a smaller service meant that service providers got to know each other and worked well together. Some participants commented on less bureaucracy in comparison with larger urban centres.

Some participants highlighted a difficulty for homeless people in giving their history, and having to give their story to many different agencies.

*"some of these people have to come out with horrendous things, you know, to actually justify it and have to do it again and again where I suppose we don't sometimes realise that some people have gone around five places in a week and have to say that same thing all over again"*

*". . . course it's all about survival so, you're going to tell people what they want to hear . . . you know instead of telling what they want"*

### 4.5.3 Improvements to services

Suggestions for improvements to services included training around issues for homeless people, increased funding, provision of supportive housing, follow up / outreach, communication, interagency working and flexibility:

*"Flexibility I think is key, I mean, even though, I mean several people have said that we do try and work with people to assist them to put more structure on their lives and I think its good for them to do that. But we also have to accept the reality that people*

*who have been damaged by their experiences are more likely to be chaotic in their attitude and their ability to actually keep appointments, to actually turn up at fixed places at fixed times, and sometimes I think there needs to be more of an understanding and more flexibility in some of the services around that"*

## 4.6 Health Promotion and Homeless People

### *4.6.1 Empowerment*

A number of participants referred to the importance of empowerment in promoting the health of homeless people. The role of services in building self esteem was stressed. While service providers saw a role in advocating for homeless people, some felt that the goal should be self advocacy and building on peer support amongst homeless people:

*". . .some sort of environment where maybe people who are homeless are in a similar situation, who can get together and can talk about it, and can then see that they're not alone and that there is help out there and there is services out there which they're entitled to. I keep on coming back to sort of empowering them as well to do it, not just, we'll do it for you, it's saying you can do it you know, you are perfectly capable of doing it as well, we'll show you the way and you know, just let them know that getting them in an environment where they can all talk together and realise that they're not the only person out there with that problem and that, you know, there is help there for them."*

*"It's a sense of enabling people towards self advocacy, obviously not everybody will be capable of self advocacy so there are times when you have to advocate for people, but I think a lot of it is that empowerment and again that touches on those issues of self esteem again and try to bring that sense of self back into the fore front"*

### *4.6.2 Existing Health Promotion*

In relation to existing health promotion the relationships developed with staff and emotional support provided through services was seen as most significant. The impact of positive relationships with staff was regarded as very important. Some participants commented on the impact even after clients had left the service and that many felt they could call back. The approach within services for homeless people was also seen as significant. Kindness, caring and listening were considered helpful. Staff also saw a role in building trust and confidence of clients.

New approaches within services were also considered important in promoting health. Some services were operating a key worker system which was regarded as providing a 'continuum of caring' and support. Some participants described how they worked with individual clients to set their own goals and assisted them in exploring their options. The after care service was also seen as beneficial.

Other examples of existing health promotion initiatives included advise from staff, personal development and other courses that were needs led, healthy diet, interagency working, improvements to accommodation, hospital discharge policy and health & safety.

Some points were raised in relation to difficulties in implementing health promotion initiatives. Difficulties included lack of funding and staff time and commitment. Lack of stability among the client group created difficulties in organising initiatives such as courses. While training was seen as a need for staff, an already busy training agenda posed problems.

### *4.6.3 Health Promotion Suggestions*

Accommodation and day activities were identified as priorities to promote the health of homeless people.

Participants provided suggestions for specific health promotion initiatives and ways of furthering health promotion for homeless people in the region.

The most commonly cited suggestion in all focus groups was the provision of a day centre. Consultation with service users was deemed important in setting up a day centre. Many suggestions were made in relation to the day centre. Several participants said that it should include a range of dedicated services in a multi-disciplinary approach. While some services could be available on site it was also suggested that a 'link' person could put people in touch with services as necessary and discuss options. Information, advice and health promotion was considered important and

the provision of courses such as literacy and skills training.

The next most frequent suggestions for health promotion were training and courses for homeless people (especially in the area of job skills), interagency working, and peer support.

Counselling, dedicated services for homeless people ( e.g. social work, PHN & GP), follow up / outreach, training in health promotion for staff, courses on health promotion topics and prevention of homelessness were also considered important:

> ***"More resources as well I think to do both follow up and outreach work, and the two are linked but they are different, . . . , by follow up I'm talking about being able to continue to support people who've moved on from services like ours, by outreach I'm talking about getting out there on the street working with people who are street homeless and identifying and being able to point them in the right direction to get their help needs met"***

Other health promotion suggestions included move on accommodation, parenting support, a needs led approach, literacy support, focus on street homelessness, a political platform for homeless people, health promotion for staff, healthy eating, mental health promotion, creativity and building on opportunities with homeless people.

# Chapter 5 – Discussion

# 5. Discussion

## 5.1 Introduction

The study aimed to identify the health concerns and health promotion needs of homeless people in the Western Health Board region. It involved undertaking one to one interviews with homeless people and focus groups with service providers. The key issues which arose in the interviews and focus groups are discussed in this section.

## 5.2 Health & Well-being

### *5.2.1 Physical Health*

The health of homeless people was generally described by focus group participants as poor. Physical health problems were associated with the homeless situation and environment. Over half of the homeless people interviewed rated their physical health as average, poor or very poor. In addition 59% reported having physical health problems with the main issues being respiratory tract, gastro-intestinal, musculoskeletal and cardiovascular health problems. These findings are consistent with other studies of homeless people in Ireland (Feeney et al 2000, Holohan 2000 and Mac Neela 1999).

Some service providers in the focus groups suggested that health may be low priority for homeless people in comparison with other issues and worries. In addition it was also stated that problems such as addiction make it difficult for them to look after their physical health. Similarly, Power and Hunter (2001) found that health concerns were not a priority in comparison with day to day issues such as shelter, food and personal safety. The study findings suggest that the homeless situation leads to a range of both short and long-term health problems. Clearly this is an area that should be addressed by providing appropriate services for homeless people. Whilst it is acknowledged that agencies do monitor the health of people in their care it is suggested that this process is standardised throughout agencies and that the Western Health Board should facilitate this process. Criteria should be developed to assess the health of homeless people when they initially contact services, including the need for referral to health services. Health should also be monitored at regular intervals thereafter. In addition, other studies of this population group (e.g. Power and Hunter, 2001) have highlighted the need for specific and accurate information on aspects of health. Agencies should also offer practical advice and information on aspects of health relevant to homeless people (e.g footcare, healthy eating etc.).

### *5.2.2 Mental Health*

Mental health problems, especially depression, were frequently identified both as a contributory factor to and a consequence of homelessness. A total of 58% of the people interviewed reported having mental health problems or illnesses, with 40% stating that they had experienced depression. Thirty four percent of people said that they were on medication for mental illness now or in the past. The high level of depression is consistent with other studies of homeless people in Dublin (Holohan, 2000 and Feeney et al, 2000). Scores using the GHQ-12 rated the people interviewed in terms of mental health as significantly poorer than the general Irish population (Fahey et al 1999). In addition the overall rating of mental health status was also rated significantly lower than the general Irish population (Evans & Jones, 2001). A number of interviewees had experienced suicidal thoughts or attempted suicide in the past.

Both the interviews with homeless people and the focus group with service providers revealed that many homeless people experienced stress, low self-esteem and poor social supports. These factors have been identified as having a negative impact on mental well-being (Health Education Authority, 1997).

The people interviewed and service providers also highlighted the need to improve existing services for homeless people with mental illness including appropriate accommodation; improving communication between doctors and patients; and extending follow up and community based services. These issues need to be addressed to further support homeless people with mental health problems.

The findings highlight the importance of dealing with mental health problems. Indeed, this appeared to be a key factor contributing to homelessness. If the health status of homeless people is to be improved their mental health issues need to be addressed. Services should be responsive to the mental health needs of homeless people. The provision of specialised mental health services and supported housing for homeless people with mental illness should respond to local need in this region. This is supported by the Amnesty International report on mental illness and homelessness (2003) which highlights the need for specialised services for homeless people who are mentally ill and for community based accommodation with appropriate mental health supports. Discussions with the mental health services in this region have identified the need for a mental health social worker and a

community psychiatric nursing service for homeless people. This should be prioritised by service providers. Criteria should be developed to assess the health of homeless people, including mental health when they initially contact services, including the need for referral to health services.

A mental health promotion programme for homeless people should be developed with the Health Promotion Service of the Western Health Board and relevant agencies. The Health Education Board for Scotland (HEBS, 2001) stress the importance of mental health promotion in increasing emotional resilience; increasing people's capacity to be effective in their community and in helping to reduce the severity of some mental health problems.

### *5.2.3 Addiction*

The majority of interviewees (83%) reported drinking alcohol at some stage in their lives. Addiction to alcohol and other substances was common with alcohol being the most common form of addiction identified. This is consistent with findings from other Irish studies of the homeless population (Holohan 2000; Feeney et al 2000).

This study identified that addiction was often associated with relationship difficulties, negative past experiences such as violence and mental health problems. The impact of alcohol abuse on homeless people and their families was described. Addiction was also found as a factor in the cycle of recurring homelessness. These findings indicate that addiction treatment is important in assisting to prevent recurring homelessness.

A third of all people interviewed reported that they had received alcohol counselling now or in the past. A number of these were currently in receipt of services. The importance of addiction counselling in assisting people was evident. Over a third of the men who ever drank alcohol said that they had given up for more than a month but used to drink heavily or had alcohol problems in the past. However, levels of alcohol use were extremely high among many current drinkers. Some of these had been in receipt of addiction treatment services and some had not. A difficulty highlighted by some participants was the lack of follow up when treatment was completed. Similarly service providers identified the importance of outreach services and follow up to help overcome the addiction. Existing outreach facilities should be reviewed to assess the need and feasibility to expand services so that they are in a better position to respond to homeless people. In addition alcohol counselling services should be reviewed with a view to increasing the uptake of services by homeless people.

### *5.2.4 Violence and abuse*

Violence and / or abuse was a significant problem for many of the homeless people interviewed. Service providers highlighted that a lot of the problems experienced by homeless people are due to violence and abuse in the past that has never been dealt with.

Gaps identified in relation to services for people who have experienced violence and / or abuse included counselling and accommodation services, including move on and transitional accommodation. These were particularly highlighted for women. The difficulties experienced by certain groups, such as Traveller women, in accessing alternate accomodation once homeless was also stressed. Services should recognise that violence and abuse would appear to be a more significant issue among homeless people than the general population and is a key factor in many people becoming homeless. Systems should be developed to identify underlying violence and abuse and to offer referral, counselling and other appropriate services. Service providers should be trained in these skills and the guidelines and protocols for professionals providing services to women and children experiencing violence produced by the Regional Planning Committee on Violence against Women (2003) should be utilised.

### *5.2.5 Social well-being*

Relationship difficulties were commonly reported with almost a third of people interviewed reporting that they did not have close personal relationships. Lack of social contact and loneliness were among the main causes of stress. Relationship difficulties were identified as a factor in becoming homeless with reports of unstable family backgrounds, abusive relationships and relationship break up. Many people expressed difficulty in talking about their problems and lack of confidence and trust due to past experiences of negative relationships.

This raises the concern that homeless people may need assistance in building relationships, this could form part of lifeskills / personal development programmes. The relationships developed with staff in hostels and houses were seen as significant in rebuilding trusting relationships. Relationships with people in similar situations were also highlighted as a source of support indicating opportunities to develop peer support. Power and Hunter (2001) and Connor et al (1999) have described the usefulness of peer support and peer health education projects with homeless groups.

The importance of day facilities was emphasised by homeless people and service providers as they provide opportunities to build social skills and social

networks. Service providers stressed the importance of facilities in relieving boredom during the day and in fostering social networks. This is supported by Morrell-Bellai at al (2000) who stress the importance of fostering social support and developing support networks for homeless people, who may not be able to develop support networks on their own. The findings stress the need for day facilities to be provided and to be utilised to build social contact.

#### *5.2.6 Spiritual well-being*

Religion or spirituality was important for the majority of homeless people interviewed stressing the importance of freedom to practice religion and express spirituality.

Religion or spirituality gave meaning to life for 21% of people. Their children gave meaning to life for 23% of people. However, more than one in ten were not able to identify anything that gave meaning in their life. Service providers also referred to a sense of hopelessness associated with the homeless situation. Despite this a greater number of people interviewed were able to identify hopes for the future. This paradox is also described by Boydell et al (2000) and Herth (1998) who describe the ability of homeless people to express a positive outlook for the future despite their distress and apparent hopelessness of their current situation.

These findings support the need to foster hope amongst homeless people. The majority identified having a home and a job as their main hopes for the future. Morrell-Bellai at al (2000) highlight the importance of providing opportunities for retraining, employment and safe, affordable housing to foster hope and to prevent helplessness and chronic homelessness. This would suggest that a long-term plan is required, which tackles the issues of retraining, employment and housing in addition to the short-term needs of homeless people. The City and County Homeless Forums and action plans should provide the medium for achieving this.

Service providers also described the strengths and the resilience of homeless people, suggesting that opportunities should therefore be developed to build on their strengths. Boydell et al (2000) also describe such resilience and reflect on the absence of literature on wellness of homeless people and on the strengths within the homeless population.

### 5.3 Accommodation and Housing

Shelter and accommodation is a basic human need (Maslow, 1954) and a human right Human Rights Network, 1994). The provision of adequate housing has been shown to be a key environmental determinant of health (Naidoo and Wills, 1998). The home was identified as one of the most important influences on health by adults in the Western Health Board region (Jones, 2001). It is therefore not surprising that the people interviewed identified housing as the most important factor in improving their quality of life. This demonstrates the need for housing policy to address the housing needs of homeless people. It is noteworthy that the vast majority of people interviewed were happy with the current accommodation provided by voluntary agencies. This however is designed to be temporary, a point acknowledged by the people interviewed who expressed a desire to 'move on.' This is an area where there appears to be considerable scope for improvement in terms of the provision of 'move on' accommodation. The people interviewed and the service providers highlighted that housing provision for homeless people should be prioritised, particularly 'halfway housing' that promotes independence and also provides follow up support. This has also been recognised in a recent review of homelessness in Northern Ireland (Health Promotion Agency, 2003). There is a clear need for the provision of additional 'move on' facilities with follow up support to be prioritised by both statutory and voluntary agencies providing services for homeless people.

There are a number of tenancy issues that were identified as being key factors in becoming homeless. These included issues such as discrimination by landlords, landlords not accepting people who require rent receipts for social welfare purposes and abuse of tenants' rights. It is important that these issues are dealt with to help prevent homelessness. This needs to be addressed by housing legislation. The Private Residential Tenancy Bill (2003) is currently being debated. In addition, existing legislation needs to be enforced in particular the Housing (Standards for Rented Houses) regulations, 1996; the Housing (Rent Books) Regulations, 1993 and the Housing (Registration of Rented Houses) Regulations, 1993. This should include routine enforcement.

### 5.4 Experiences of Homelessness

#### *5.4.1 Pathways to homelessness*

The service users and service providers who participated in this study described a number of factors which contributed to homelessness. These included mental health problems, addiction, domestic violence, abuse, relationship break up, unstable family backgrounds, lack of social support, lack of integration on return from emigration, leaving

institutional care, lack of safe affordable housing, tenancy problems and poverty resulting in eviction. Many factors were interlinked and most people experienced a number of these problems. Similar factors were identified by other studies including Feeney et al (2000). Poverty was also identified as a key factors in people becoming homeless. Poverty is widely recognised as having a negative effect on health (Dept of Health and Children, 2000) highlighting that the needs of those who are poorer in our society should be prioritised (Irish Government, 1996).

Service providers described cycles associated with homelessness including recurring homelessness, and the cyclic nature of factors contributing to homelessness. This highlights the complex nature of homelessness and the contributing factors. It also reinforces the need for a multifaceted approach with all agencies working together to respond to the needs of homeless people and those at risk of homelessness. The need to develop measures to prevent homelessness is also evident. The creation of City and County based Homeless Forums has been an important step towards achieving this.

### *5.4.2 The impact of homelessness*

The trauma of homelessness and in particular the trauma of sleeping rough was graphically described by people in this survey. The negative impact of homelessness and the associated social exclusion, isolation and vulnerability of the homeless situation is widely accepted particularly in a society that values housing and having a home. Service providers stressed the negative effect of homelessness on self-esteem. This was seen to impact on the confidence of homeless people to seek support or link with services. This finding highlights the need for lifeskills / personal development programmes and creating opportunities to promote self-esteem.

Service providers also highlighted the impact of the instability of the homeless situation and of the stigma and discrimination towards homeless people. Projects to reduce stigma and discrimination should be developed within services and within the general public. Initiatives such as the 'Shelter from the Storm' video and involving homeless people in the 'Health Links' newspaper have used various media to highlight the situation of homeless people in this region. Expanding such initiatives may assist in promoting self-esteem and reducing the stigma of homelessness.

## 5.5 Services

In recent years the issue of equity and accessibility of services has been the cornerstone of Government strategy, particularly in the health sector (Dept. of Health and Children, 2002). Crisis UK (2002) found that while the health needs of homeless people are greater their access to care is poorer than that of the general public. This highlights the need for services to be in a position to respond to the needs of homeless people and to ensure equity and accessibility. However, many of the people interviewed stressed that services were not meeting their needs and that they had experienced difficulties with services. Common difficulties experienced were not knowing where to go to get a service, being passed around from one service to another, and being discriminated against when trying to use a service. Services in particular that were highlighted for improvement were the provision of housing / accommodation and health services. Service providers who participated in the focus groups highlighted that homeless people find it more difficult to access services. Ensuring access to primary care services has been emphasised as essential to impact on the health of homeless people (Feeney et al, 2000, Crisis UK, 2002, Croft-White and Rayner, 1999) Service providers in this study stressed the lack of follow up and community based services. These findings highlight the need for agencies to work together to improve the level of co-ordination between services, to ensure easy and appropriate referral between services. Having a specific location where people can access information and advice and referral to services may facilitate the process. It also reinforces the need for more accommodation facilities (section 5.3) and community based services. Service providers should also ensure that services are fair and non-judgemental. This may require additional training, and opportunities for training on issues relevant to homeless people should be developed within statutory and voluntary services. This could be similar to the culture awareness training currently provided for health care staff in relation to Traveller culture and identity. An evaluation of this training (Evans, 1999) found that the vast majority of course participants had a better understanding of the barriers Travellers experience in accessing services and were more sensitive to their needs.

Another issue in terms of the provision of services is that almost half of the homeless people interviewed had missed appointments or had not attended services when advised to do so. Reasons given by people interviewed and service providers included negative feelings (e.g. fear, shyness), low self-esteem, negative past experiences of using

services and difficulties in keeping appointments. This suggests that services need to adopt a flexible approach to individuals who experience difficulties in using services.

## 5.6 Health Promotion Plan

### *5.6.1 Health Promotion initiatives*

‘ Effective health promotion leads to changes in the determinants of health, both those within the control of individuals (such as health behaviours and the use of health services), and those outside of their control such as social, economic and environmental conditions. Poverty, housing standards, clean water - all these affect the health status of people’
(International Union for Health Promotion and Education, 2000, pg 2)

It is widely recognised that for health promotion to be effective the broader determinants of health should be addressed. These include poverty, housing, education and employment. The findings of this study showed that these factors need to be addressed to improve the well-being and quality of life of homeless people. Health promotion is concerned with tackling the determinants of health and prioritising the reduction of health inequalities. The home setting, including the emotional environment was identified as one of the most important determinants of health on health in the Western Health Board region (Jones, 2001). The National Health Strategy (Dept of Health and Children, 2001) states that initiatives to improve the health and well-being of homeless people should be advanced, in order to reduce health inequalities, and that the Homelessness Strategies should be implemented (Obj.3, Action 21). The recommendations of existing policy and strategies in relation to homelessness and health should be prioritised and the wider determinants of health should be addressed to reduce the inequality in health experienced by homeless people.

The Health Promotion Strategy ‘Promoting Health in the West 2003-8’ (WHB, 2002) highlights the role and responsibility of all health care workers and services in promoting health. The need for partnerships with other agencies, to address the determinants of health, is also stressed. The people interviewed in this study highlighted the need for services to be more health-promoting. This included addressing discrimination and providing an understanding approach in agencies; providing an equitable health service and providing additional and improved services for homeless people. Opportunities for partnership working and training, within the Health Board and externally, should be maximised to enable services to be health-promoting in their approach and to address the issues that affect homeless people.

Health promotion focuses on physical, mental/emotional, social and spiritual dimensions of health. Emotional support provided through services for homeless people and relationships developed with staff was highlighted by service providers as most significant in relation to existing health promotion. This needs to be built on to help achieve a holistic approach to promoting the health and well-being of homeless people.

Provision of a day centre was prioritised by the people interviewed and service providers as an initiative to further promote the health of homeless people. This was seen as a facility for providing services, information, advice and training for homeless people. The importance of a multidisciplinary approach was highlighted with the provision of dedicated services on site and links to other relevant services. Opportunities for creating social networks through the day centre and the importance of consultation with service users was also stressed. A report compiled by Cope (O’Connor, 2002) proposed the development of a day centre for homeless people in Galway city, and suggested models of service provision. This study lends support to the development of such facilities. The experience of day centres in other parts of the country should be considered when developing day facilities.

Service providers referred to the importance of empowerment in promoting the health of homeless people. Empowerment is a key principle of health promotion and should be a central part of any health promotion initiative. Power, French et al (1999) in considering the key elements needed in any health promotion intervention for homeless people highlight the importance of participation of service users, use of an holistic approach and including measures to increase self-esteem, confidence and create trust.

### *5.6.2 Information*

In order to facilitate the use of services by homeless people, it is important that they can access relevant user friendly information. It appears that there is not enough information currently available, as almost two thirds of the people interviewed stated that more information would be of use to them. The greatest information need was in relation to entitlements and health information. Hostels / houses, Citizen’s information centres and welfare offices were

regarded as best placed to provide information. Relevant, user friendly information should be made available to homeless people. Guidelines from the National Adult Literacy Association (NALA) and the Health Promotion service should be considered when producing written material. The use of other media and the provision of one-to-one information should be explored.

### *5.6.3 Lifestyle factors*

Previous studies have indicated that the prevalence of risk factors for chronic diseases is higher amongst the homeless population than the general public (Feeney et al, 2000 and Holohan and Holohan, 2000). Risk factors included smoking, excessive use of alcohol and other substances and poor diet.

The prevalence of smoking among people interviewed was very high at 80%. This is similar to findings of other studies with homeless people in Ireland (Feeney et al 2000) and significantly higher than smoking prevalence in the general population. The SláN survey (2002) reported rates of 27% among the general public.

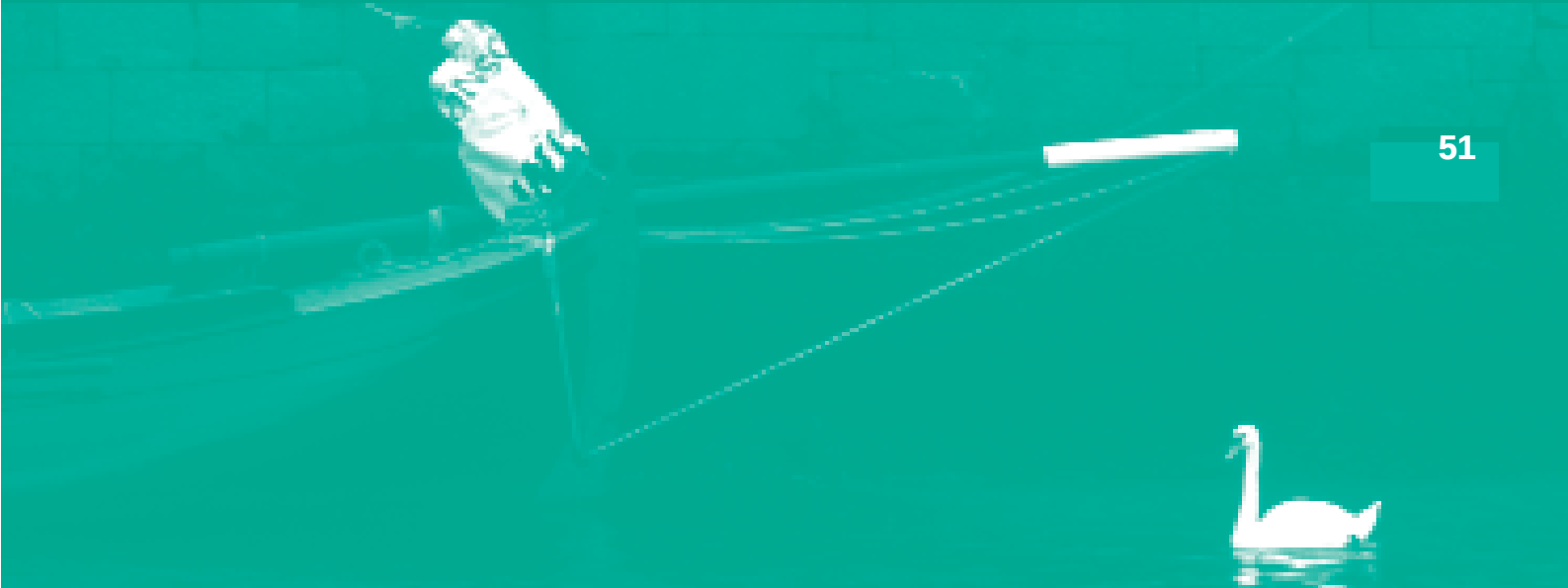
A significant number of interviewees had concerns about their diet. Focus group participants highlighted the impact of lack of cooking facilities and affordable healthy food options on the diet of homeless people. This would indicate that support is needed in relation to healthy nutrition on a budget. Some services for homeless people have availed of the Western Health Board community nutrition and Home Management services and this should be extended to other services.

Sixty two percent of people interviewed reported alcohol consumption in the last month. The levels of alcohol use were extremely high with 48% of men, who had drank in the last month, drinking over the recommended level of 21 units a week and 20% of women, who had drank in the last month, drinking over the recommended level of 14 units a week. Excessive levels of alcohol use were reported. Half of the people who reported alcohol consumption in the last month scored 2 or greater on the CAGE alcohol screening instrument indicating alcohol problems. In relation to drug use forty two percent of homeless people who had used drugs scored 1-2 indicating low level of problems; 24% scored 3-5 or moderate level problems. Thirty five percent of people who had used drugs scored over six indicating need for intensive assessment.

Findings in relation to exercise were very positive with levels of moderate exercise significantly higher than the general population. Exercise was also identified by homeless people as a means of coping with stress.

The interviews and focus groups highlighted the impact of addiction problems and the need to provide further addiction treatment for homeless people. In addition there may be opportunities within services to promote safe drinking. Support in relation to smoking cessation and healthy eating is also needed. Service providers in facilities for homeless people may be in a position to promote healthy lifestyles. In order to do this training may be required. Training needs of service providers should be assessed and training should be provided by the Health Promotion service of the Western Health Board with other relevant services such as the Drug Services.

# Chapter 6 – Recommendations



# 6. Conclusions and Recommendations

## 6.1 Conclusions

It is evident from this study that homeless people are particularly vulnerable in terms of health. Their service needs are great and that they should be prioritised in terms of accommodation, health care and other support services. An interagency approach is necessary to address the health needs of homeless people. Opportunities to promote the health and well-being of homeless people should be developed. A multifaceted approach should be achieved with all agencies working together to address the complex issues which contribute to homelessness, to respond to the needs of homeless people and to develop measures to prevent homelessness.

## 6.2 Recommendations

Many of the issues raised in this study have also been identified by the homeless forums in this region. The City and County Homeless Forums and Action Plans should provide a medium for addressing the recommendations of this report. From the research the following recommendations are made:-

- The recommendations of existing policy and strategies in relation to homelessness and health should be prioritised and the wider determinants of health should be addressed to reduce the inequality in health experienced by homeless people.

- All agencies for homeless people should develop standardised criteria to assess the physical and mental health of homeless people on initial contact with their service. The Western Health Board should facilitate this process.

- Agencies should provide practical advice and information to homeless people on relevant aspects of health.

- Alcohol counselling and treatment services, including outreach facilities, should be reviewed with a view to increasing the uptake of services by homeless people.

- The provision of specialised mental health services and supported housing for homeless people with mental illness should respond to local need in this region. The provision of a mental health social worker and a community psychiatric nursing service for homeless people should be prioritised.

- A mental health promotion programme for homeless people should be developed with the Health Promotion Services of the Western Health Board and relevant agencies.

- Systems should be developed to identify underlying violence and abuse and to offer referral, counselling and other appropriate services. Service providers should be trained in these skills and the guidelines and protocols for professionals providing services to women and children experiencing violence (2003) should be utilised.

- Day facilities should be provided in consultation with homeless people and with a multidisciplinary approach. They should be utilised to build social skills and social networks. Day facilities should include services, information, advice and training for homeless people.

- Opportunities for peer support amongst homeless people should be developed.

- Lifeskills / personal development programmes should be provided for homeless people.

- Opportunities should be developed to build on the strengths of homeless people, to utilise existing skills, and gain opportunities to develop skills and interests.

- Long-term plans for homeless people should address the issues of retraining, employment and housing.

- Provision of additional ‘move on’ facilities with follow up support should be prioritised by both statutory and voluntary agencies providing services for homeless people.

- Existing housing legislation needs to be enforced in particular the Housing (Standards for Rented Houses) regulations, 1996; the Housing (Rent Books) Regulations, 1993 and the Housing (Registration of Rented Houses) Regulations, 1993. This should include routine enforcement.

- Various media should be utilised to promote the self-esteem of homeless people and to reduce the stigma of homelessness.

- Agencies should work together to improve the

level of co-ordination between services and to ensure easy and appropriate referral.

- Measures should be taken to ensure that homeless people have equitable access to essential services such as primary health care.

- A specific location should be provided where homeless people can access information and advice and referral to services. Community based and follow up services should be further developed.

- Opportunities for partnership working and training, within the health board and externally, should be maximised to enable services to be health-promoting in their approach by providing an open, understanding approach, addressing discrimination, providing an equitable services and addressing the issues that affect homeless people.

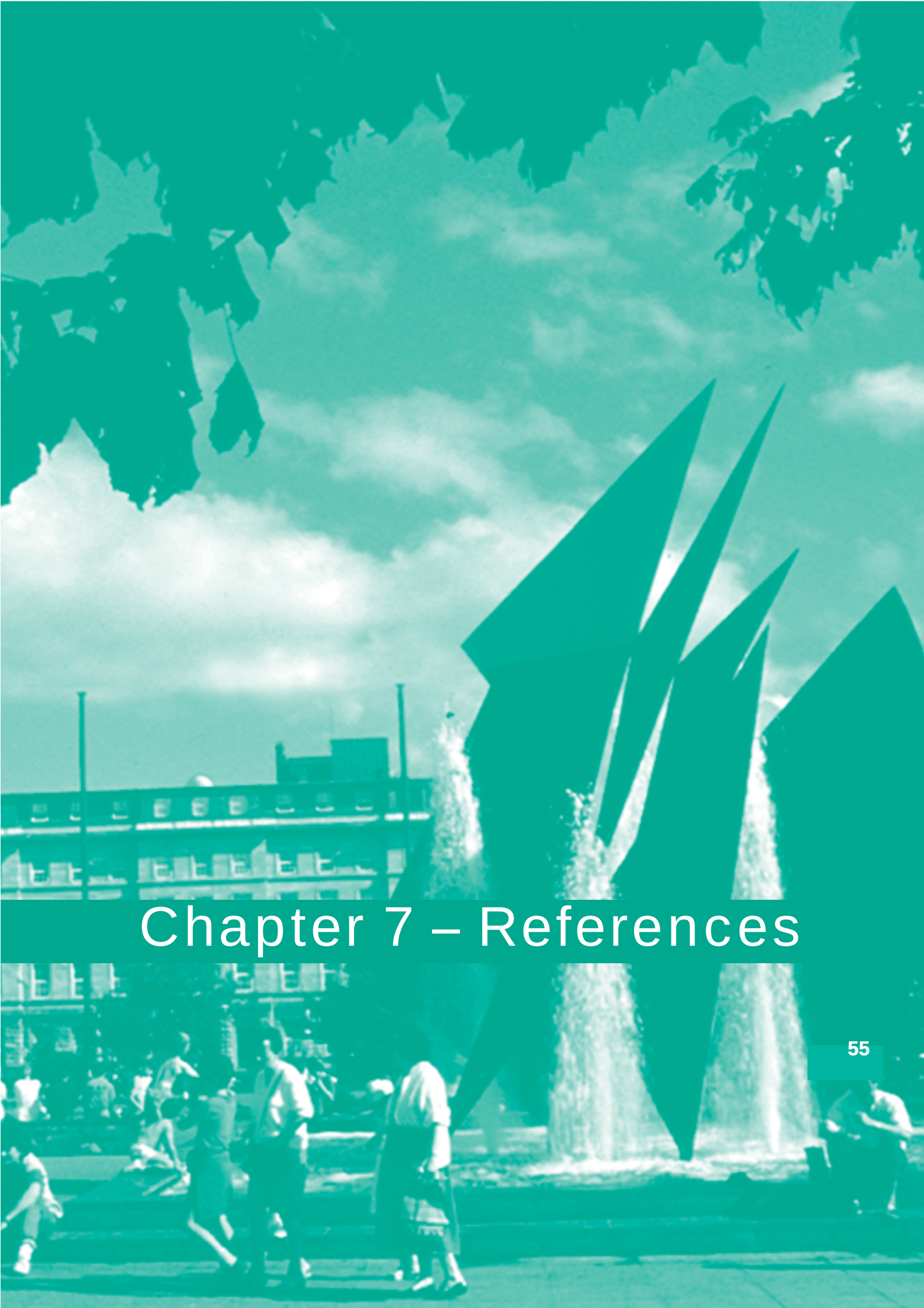
- Training on issues relevant to homeless people should be developed within statutory and voluntary services, to help ensure that services are fair and non-judgemental.

- Empowerment should be a key principle of health promotion initiatives.

- Relevant, user friendly information on issues such as entitlements and health information and services should be made available to homeless people through voluntary services, Citizen's information centres and welfare offices. Guidelines from the National Adult Literacy Association (NALA) and Health Promotion Services should be considered when producing written material. The use of other media and provision of one to tone information should be explored.

- Support should be provided for homeless people in relation to smoking cessation, healthy eating and safe drinking. This should form part of the programmes provided by relevant services of the Western Health Board.

- Training needs of service providers in relation to health promotion should be assessed by Health Promotion Services of the Western Health Board and appropriate training should be provided in conjunction with other relevant services.



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# Appendix 1

# Appendix 1– Interview Schedule

Interview No. (for office use)

Interviewer

Date & time

Location

## Introduction

Hello. Good morning/afternoon/evening, my name is …….. I am carrying out a survey about health to help improve services in the region. I'd like to ask you some questions.
I would like to find out about your situation and your physical and mental health. I also would like to find out what might help to improve things for you and other people in a similar situation.

## Confidentiality

The information you give me to-day is confidential and I will not be using your name in connection to anything you tell me.

## Section 1

***Demographics***
First I need to get some general details.

**Q.1**
What age are you? _____

| | |
|---|---|
| 18-24 | 1 |
| 25-34 | 2 |
| 35-44 | 3 |
| 45-54 | 4 |
| 55-64 | 5 |
| 65+ | 6 |

**Q.2**
What is your nationality?

| | |
|---|---|
| Irish | 1 |
| British | 2 |
| EU not 1 or 2 | 3 |
| Non EU citizen | 4 |

**Q.3**
What is your marital status?

| | |
|---|---|
| Single | 1 |
| Married | 2 |
| Separated | 3 |
| Divorced | 4 |
| Widowed | 5 |

**Q.4**
Do you have children?

| | |
|---|---|
| Yes | 1 |
| No | 2 |

If yes, how many?

How many are under 18?

## Current situation

Now I'd like to ask you about your situation at the moment & where you staying at the moment.

**Q.5**
What county do you live in?

(Circle those that apply)

| | |
|---|---|
| Galway | 1 |
| Mayo | 2 |
| Roscommon | 3 |
| Other Specify | 4 |

**Q.6**
How long have you been living in _____? (name county)

years
months
weeks
days

**Q.6a**
If Irish, What county are you originally from?

**Q.7**
You are living here at_____ (name place )

Can you tell me how long you have been living here ?
years
months
weeks
days

**Q.8**
How did you come to be living here?
PROBE & RECORD VERBATIM

**Q.9**

Where were you living before this ?
PROBE & RECORD VERBATIM

## Section 2

***General Wellbeing***

The next questions are about your health in general.

**Q.10**

What do you do to look after your own health?
RECORD VERBATIM

## Section 3

***Physical Well-being***

The next questions are about your physical health and any health complaints you may have.

**Q.11**

First I would like to ask how your own physical

Would you say that it is . . .

| | | |
|---|---|---|
| SHOW Scale | Very good | 1 |
| | Good | 2 |
| | Average | 3 |
| | Poor | 4 |
| | Very poor | 5 |
| | Don't know | 6 |

**Q.12**

Do you have any physical health problems or illnesses?

Yes
No

If yes, what physical health problems or illnesses do you have?
PROBE & RECORD VERBATIM

## Section 4

***Mental Well-being***

Next, I would now like to ask you about your mental health and & how you are feeling generally.
Mental health means being able to enjoy life and to cope when things go wrong.

**Q.13**

I would like to ask how your own mental health is at the moment.

Would you say that it is . . .

| | | |
|---|---|---|
| SHOW Scale | Very good | 1 |
| | Good | 2 |
| | Average | 3 |
| | Poor | 4 |
| | Very poor | 5 |
| | Don't know | 6 |

Now, a question on stress
Stress can be caused by many things, like . . .
[ROTATE & ¸ START]

❑ Day to day worries

❑ Family or relationship problems

❑ How other people treat you

❑ Money problems

❑ Health problems

**Q.14a**

What causes you most stress?
PROBE & RECORD VERBATIM

**Q.14b**

What do you do to deal with stress?
PROBE & RECORD VERBATIM

The next questions will ask a little bit more about your mental health and how you've been feeling generally over the last few weeks. I am going to read out a list of statements and ask you which answer you think applies to you.

## Scales

**Q.15**

Have you recently … (repeat for each question)

a) Been able to concentrate on whatever you're doing?

| | | | | |
|---|---|---|---|---|
| B | Better than Usual | Same as usual | Less than usual | Much less than Usual |
| | 1 | 2 | 3 | 4 |

b) Lost much sleep over worry?

| | | | | |
|---|---|---|---|---|
| C | Not at all | No more than usual | Rather more than usual | Much more than usual |
| | 1 | 2 | 3 | 4 |

c) Felt that you are playing a useful part in things ?

| | | | | |
|---|---|---|---|---|
| D | More so than usual | Same as usual | Less useful than usual | Much less useful |
| | 1 | 2 | 3 | 4 |

d) Felt capable of making decisions about things?

| | | | | |
|---|---|---|---|---|
| E | More so than usual | Same as usual | Less so than usual | Much less than usual |
| | 1 | 2 | 3 | 4 |

e) Felt constantly under strain?

| | | | | |
|---|---|---|---|---|
| C | Not at all | No more than usual | Rather more than usual | Much more than usual |
| | 1 | 2 | 3 | 4 |

f) Felt you couldn't overcome your difficulties?

| | | | | |
|---|---|---|---|---|
| C | Not at all | No more than usual | Rather more than usual | Much more than usual |
| | 1 | 2 | 3 | 4 |

g) Been able to enjoy your normal day-to-day activities?

| | | | | |
|---|---|---|---|---|
| E | More so than usual | Same as usual | Less so than usual | Much less than usual |
| | 1 | 2 | 3 | 4 |

h) Been able to face up to your problems?

| | | | | |
|---|---|---|---|---|
| F | More so than usual | Same as usual | Less so than usual | Much less able |
| | 1 | 2 | 3 | 4 |

i) Been feeling unhappy and depressed?

| | | | | |
|---|---|---|---|---|
| C | Not at all | No more than usual | Rather more than usual | Much more than usual |
| | 1 | 2 | 3 | 4 |

j) Been losing confidence in yourself?

| | | | | |
|---|---|---|---|---|
| C | Not at all | No more than usual | Rather more than usual | Much more than usual |
| | 1 | 2 | 3 | 4 |

| l) | Been thinking of yourself as a worthless person? | | | |
|---|---|---|---|---|
| C | Not at all | No more than usual | Rather more than usual | Much more than usual |
| | 1 | 2 | 3 | 4 |

| m) | Been feeling reasonably happy all things considered? | | | |
|---|---|---|---|---|
| G | More so than usual | About the same as usual | Less so than usual | Much less than usual |
| | 1 | 2 | 3 | 4 |

**Q.16**

Do you have any mental health problems or illnesses?

Yes 1 No 2

If yes, what mental health problems or illnesses do you have?
PROBE & RECORD VERBATIM

## Section 5

***Social Well-being***

I'm now going to ask you some questions about the people you spend time with. These are people with whom you have more than a casual relationship. These people could be family or friends. These are: people you trust, or people you see regularly or people you talk to about personal problems.

**Q.17a**

Do you have people that are important in your life?
If yes go to Q.17b
If no, go to Q.18

Yes 1 No 2

**Q.17b**

Are the people that are important in your life family or friends?
If 1 or 3, go to Q.17c
If 2 only, go to Q.17d
Family 1 Friends 2
Both family & friends 3

**Q.17c**

If family, what relationship are they to you? (Circle those that apply)

| | Yes | No | How often to you meet /have contact with. . (insert appropriate no. from scale below) |
|---|---|---|---|
| Parent | 1 | 2 | |
| Sibling | 1 | 2 | |
| Spouse / partner | 1 | 2 | |
| Son/ Daughter | 1 | 2 | |
| Aunt / Uncle | 1 | 2 | |
| Grandparent | 1 | 2 | |
| Cousin | 1 | 2 | |
| Other | 1 | 2 | |
| Specify | | | |

Frequency scale for q.17c (Please insert appropriate number in 3rd column above)

| | |
|---|---|
| Every day | 1 |
| 2-3 times a week | 2 |
| Once a week | 3 |
| Once a fortnight | 4 |
| Once a month | 5 |
| Once every 3 months | 6 |
| Once in 6 months | 7 |
| Once a year | 8 |
| Less often | 9 |
| Never | 10 |
| Don't know | 11 |

**Q.17d**

Do you have as much contact as you would like with people that are important to you?

Yes 1 No 2

**Q.18**
Do you have close, personal relationships (people you can turn to, people you can talk to about how you are feeling , the good & bad things in your life)?

Yes 1 No 2

PROBE & RECORD VERBATIM

**Q.19**
Are there other people you have regularly have contact with?

Yes 1 No 2

If Yes, where do you meet them
RECORD VERBATIM

**Q.20**
Who do you turn to if you need help / to talk about things?
RECORD VERBATIM

**Q.21**
What would help you to have more contact with other people?
RECORD VERBATIM

## Section 6

***Spiritual well-being***

I am now going to ask you about meaning in your life

**Q.22**
What gives you a sense of meaning in your life?
PROBE & RECORD VERBATIM

**Q.23**
What are your hopes for the future?
PROBE & RECORD VERBATIM

**Q.24**
Does religion play an important part in your life ?

Yes 1 No 2

## Section 7

***Environmental well-being***

The next few questions are about where you live & living conditions

**Q.25**
How satisfied are you with where you live at the moment?

SHOW Scale

| | |
|---|---|
| Very dissatisfied | 1 |
| Dissatisfied | 2 |
| Neither satisfied or dissatisfied | 3 |
| Satisfied | 4 |
| Very satisfied | 5 |

**Q.26a**
Do you have concerns about where you live at the moment ?

Yes 1 No 2

**Q.26b**

If yes, what are your concerns?

RECORD VERBATIM

**Q.27a**

Does where you live affect your health in any way ?

Yes 1 No 2

**Q.27b**

If yes, in what way?

RECORD VERBATIM

**Q.28a**

Do you have any concerns about your safety?

Yes 1 No 2

**Q.28b**

If yes, in what concerns?

RECORD VERBATIM

**Q.29a**

Have you in the past had no where to stay?

Yes 1 No 2

**Q.29b**

If yes, Would you like to tell anything about what that was like?

PROBE & RECORD VERBATIM

**Q.30**

What could help to improve your living conditions?

RECORD VERBATIM

## Section 8

***Access to service***

Now a few questions on services that you may have used.

**Q.31**

How often have you had contact with the following services in the past year?

| | GP/ Local doctor | Public Health Nurse | Hospital A&E - Casualty | Hospital ward - inpatient | Dentist | Optician | Pharmacy/ Chemist | Social worker |
|---|---|---|---|---|---|---|---|---|
| Every Day | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2-3 times a week | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Once a week | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Once a fortnight | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Once a month | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Once every 3 months | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| Once in 6 months | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| Once a year | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| Less often | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |
| Never | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |
| Don't know | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 |

| | Addiction counselling service | Psychiatric services (e.g.community psychiatric nurse, psychiatric doctor, OT social worker | Community welfare officer | City council (corporation) / county council | St Vincent de Paul | Simon | Cope | Mayo Women's Support service |
|---|---|---|---|---|---|---|---|---|
| Every Day | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2-3 times a week | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Once a week | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Once a fortnight | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Once a month | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Once every 3 months | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| Once in 6 months | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| Once a year | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| Less often | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 |
| Never | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 |
| Don't know | 11 | 11 | 11 | 11 | 11 | 11 | 11 | 11 |

Other Please specify _____

| Every day | 2-3 times a week | Once a week | Once a fortnight | Once a month | Once every 3 months | Once in 6 months | Once a year | Less often | Never | Don't know |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |

**Q.31b**

If yes, to contact with Addiction services above
Where was that at?

RECORD

I am now going to go through a list to see if you have experienced any difficulties in using services

**Q.32a**

**Have you ever . . . . .**
**(repeat for each item)**

(Circle those that apply)

| | Yes | No |
|---|---|---|
| Been refused a service | 1 | 2 |
| Been passed around from one service to another | 1 | 2 |
| Not known where to go to get a service you needed | 1 | 2 |
| Felt that a service did not meet you needs | 1 | 2 |
| Not been able to use a service because it w as too far away | 1 | 2 |
| Felt that you were discriminated against when you tried to use a service | 1 | 2 |

**Q.32b**

**Have you any other difficulties using services?**

Yes 1 No 2

If yes, what difficulties?
RECORD VERBATIM

**Q.33**

**Have you ever not attended a service when advised to do so?**

Yes 1 No 2

If yes, for what reason?
RECORD VERBATIM

**Q.34a**

**What would help to improve services for you and others?**

RECORD VERBATIM

**Q.34b**

**Are there any services you would like to see more of?**

Yes 1 No 2

If yes, what services would you like to see more of?

**Q.35a**

**Do you have a medical card?**

Yes 1 No 2

If yes, go to question Section 9
If no continue to Q.35b

**Q.35b**

**Have you had any difficulty in getting a medical card?**

Yes 1 No 2

**Q.35c**

**If yes, have you experienced any of the following difficulties?**
(Circle those that apply)

| | Yes | No |
|---|---|---|
| Difficulty in filling out the forms | 1 | 2 |
| Difficulty in getting a doctor to take me on their lists | 1 | 2 |
| Don't know where to apply for a medical card | 1 | 2 |
| Other | 1 | 2 |
| Specify | | |

## Section 9

***Health Behaviour***

Can I ask you

**Q.36**

Do you smoke?

Yes 1 No 2

If yes, how many cigarettes do you smoke a day

**Q.37a**

Do you drink alcohol ?

Yes 1 No 2

If no, go to Q.40

**Q.37b**

If yes...

How many drinks do you have on average per week?

| | |
|---|---|
| Shandy | |
| Beer, lager, stout, cider | |
| Spirits or liqueurs | |
| Sherry | |
| Wine | |
| Other | |

**Q.38**

| | Yes | No |
|---|---|---|
| Have you ever felt you should cut down on your drinking? | 1 | 2 |
| Have people annoyed you by criticising your drinking? | 1 | 2 |
| Have you ever felt bad or guilty about your drinking? | 1 | 2 |
| Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? | 1 | 2 |

Q.39

| | Yes | No |
|---|---|---|
| Have you used drugs other than those required for medical reasons? | 1 | 2 |
| If yes, continue | | |
| If no, move to Q. 41 | | |

| | | |
|---|---|---|
| Do you use more than one drug at a time? | 1 | 2 |
| Are you unable to stop using drugs when you want to? | 1 | 2 |
| Have you ever had blackouts or flashbacks as a result of drug use? | 1 | 2 |
| Do you ever feel bad or guilty about your drug use? | 1 | 2 |
| Have other people ever complained about your drug use? | 1 | 2 |
| Have you neglected your family because of your use of drugs? | 1 | 2 |
| Have you engaged in illegal activities in order to obtain drugs? | 1 | 2 |
| Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | 1 | 2 |
| Have you ever had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding) ? | 1 | 2 |

**Q.40**

Has your drinking or drug use ever led to the following?

(Circle those that apply)

| | Yes | No |
|---|---|---|
| Feelings of depression | 1 | 2 |
| Aggression | 1 | 2 |
| Trouble with authorities | 1 | 2 |
| Memory loss | 1 | 2 |
| Has your drinking led to any other problems, If yes, what problems Specify | 1 | 2 |

**Q.41**

Do you have any concerns about your diet (the food you eat)?

Yes 1 No 2

If yes, what concerns do you have?
RECORD VERBATIM

**Q.42**

How many times in an average week do you do the following kinds of exercise for more than 20 minutes?

| | Times per week |
|---|---|
| a) strenuous exercise<br>e.g.running, football | |
| b) moderate exercise<br>e.g.fast walking,<br>easy swimming | |
| c) mild exercise<br>e.g. easy walking | |

## Section 10

***Information***

I would like to ask you a few questions about the kinds of information that might be of use to you.

**Q.43**

Do you currently have enough information on the following?

(Circle those that apply)

| | Yes | No |
|---|---|---|
| Health services | 1 | 2 |
| Other services | 1 | 2 |
| Out of hours services | 1 | 2 |
| Health Information | 1 | 2 |
| Entitlements | 1 | 2 |
| Other areas<br>Please Specify | 1 | 2 |

**Q.44a**

Would more information be helpful to you?

Yes 1 No 2

If yes, go to Q.44a

If no, go to Q. 44d

**Q.44b**

What would you like more information on?

RECORD VERBATIM

**Q.44c**

What is the best way to get that information to you?

RECORD VERBATIM

**Q.44d**

Do you have any difficulty getting information at the moment?

Yes 1 No 2

If Yes, What types of information, what types of difficulties?

**Q.45a**

Do you have any difficulty reading?

Yes 1 No 2

**Q.45b**

Do you have any difficulty writing?

Yes 1 No 2

If yes to either of the above go to Q.45c

**Q.45c**

Would you like help with reading or writing?

Yes 1 No 2

## Section 11

***Health Promotion***

The next few questions are asking for your opinion on what could improve your health and your quality of life.

Q.46a

Which of the following comes closest to expressing how you feel about your quality of life at the moment?

| SHOW Scale | |
|---|---|
| Delighted | 1 |
| Pleased | 2 |
| Mostly satisfied | 3 |
| Mixed | 4 |
| Mostly dissatisfied | 5 |
| Unhappy | 6 |
| Terrible | 7 |

**Q.46b**

What would help to improve your quality of life?

PROBE & RECORD VERBATIM

**Q.47a**

From this research we are going to develop a plan to improve health, what do you think should be included in the plan?

PROBE & RECORD VERBATIM

**Q.47b**

The following areas might be included in the health promotion plan.
Which would be the top three priorities for you?

| | |
|---|---|
| Information on how to look after your health | 1 |
| A day centre to go to for your health & all your information needs | 2 |
| Courses to develop new skills | 3 |
| Counselling | 4 |
| Opportunities to mix with others & social activities | 5 |
| Opportunities to develop new interests or hobbies | 6 |
| Group work | 7 |
| Courses on coping with stress & communication | 8 |
| Information / courses on healthy lifestyles e.g. healthy eating, exercise, stopping smoking & safe drinking | 9 |
| Other, please specify | 10 |

## Section 12

***Further Comments***

Before we finish is there anything else that you would like to say or anything you would like to comment on.

**Q.48**

Are there any further comments you would like to

RECORD VERBATIM

Thank you very much for your time and for your contribution to the research.

The results will help to improve services in this area. I would like to reassure you again that the information you have given me is confidential and your name will not appear anywhere.

# Appendix 2

# Appendix 2 – Focus Group Topic Guide

The topic guide is a flexible framework for the discussions, and ideas for questions to generate conversation and discussion.

The sections consist of general open-ended questions (in italics), open –ended questions for each section (in bold) and the detailed probe questions (normal, indented). The detailed probe questions will only be used if conversation dries up or to guide the discussion if certain issues have not been mentioned.

### Introduction (structured)

***Background information***

My name is . . . . . I am a researcher with the WHB and I am exploring the health promotion needs of homeless people in this area. This will assist in developing a plan for health promotion projects for homeless people.

***Confidentiality***

All the information given here today is confidential and will not be available to anyone other than the research team.

***Consent for taping***

We would like to get your consent to tape record today's discussion to ensure that we have a complete transcript of what people have said. If you would like access to the transcript at a later stage, please contact us.

As you can see from the flip chart these are main things we want to learn about:

## Main areas

What are the health education & health promotion needs of homeless people
What is being /has been done to meet these needs at the moment
How can these needs best be met
What services are currently being used
What form of health promotion would be most relevant

We want to hear all you have to say on the subject so feel free to talk to each other.

### Introductions

We will start by introducing ourselves. If you could say a little bit about yourself, & where you work.

## Section 1: The health status of homeless people in the region

***Aims of the discussion question:***

To explore the health status of homeless people currently using services in the West of Ireland. To identify some of the determinants of health for homeless people.

### General Question:

**What do you think of the health & well-being of homeless people who use your service?**

How would you describe the health & well-being of homeless people who use your service?

- Do you think that homeless people are a healthy group of people?
- In what way are they healthy?
- In what way are they not healthy?
- What are the positive things about their health & well-being?
- What are the negative things about their health & well-being?
- Do the homeless people that you have worked with suffer many illnesses?

## Other aspects of health & well-being?

*{You have mentioned the physical health of homeless people, we would also like to explore other aspects of health & well-being including mental, social, spiritual & environmental well-being}*

How would you describe the mental well-being of homeless people you have worked with?
*{"Mental health means having the mental and emotional resources to enjoy life and to cope when things go wrong". - Suicide Prevention – A Shared Endeavour – 2001.}*

- Do you think that homeless people have the mental and emotional resources to enjoy life and to cope when things go wrong?
- What are the main causes of stress in the lives of homeless people?
- Do you think that depression or mental illness is a problem among homeless people?
- Do homeless people talk openly about anxiety / depression?
- Do many homeless people go to the doctor about this?

How would you describe the social well-being of homeless people you have worked with?

In general do the homeless people you work with have close personal relationships?
What contact do they have with other people?
Where or who do they generally turn to if they need help or to talk about things?
Are there any other issues for homeless people in the area of relationships and social well-being?

How would you describe the environmental well-being of homeless people you work with?
How do the living conditions of homeless people affect their health & well-being?
What do you think influences the health & wellbeing of homeless people?

Do homeless people you have come in contact with have a sense of hope for the future?
What are some of their hopes?
What gives them purpose in their lives?

## Section 2 : Use of services

***Aims of the discussion question:***

To examine the use of services among homeless people. To explore issues in relation to accessibility and availability of services.

**General Question:**
**What do you think of the services for homeless people in this area?**

What are the main health services that homeless people use in this area?
Do homeless people know of other services that are available?
What do you think about the health services for homeless people in this area?
What do you think about the service that homeless people receive?
Do you think that health services are accessible to homeless people?
Are services easy to get to?
Do the health services cater for the needs of homeless people?
Are homeless people treated fairly?
Do men use the services as much as women do?

What are the other statutory services that homeless people use in this area?
Do homeless people know of other services that are available?

What do you think about the services provided by other statutory agencies for homeless people in this area?

What do you think about the service that homeless people receive?
Do you think that the services are accessible to homeless people?
Are services easy to get to?
Do the services cater for the needs of homeless people?
Are homeless people treated fairly?

What are the voluntary services that homeless people use in this area?
Do homeless people know of other services that are available?

What do you think about the services provided by voluntary/community agencies for homeless people in this area?
What do you think about the service that homeless people receive?
Do you think that the services are accessible to homeless people?
Are services easy to get to?
Do the services cater for the needs of homeless people?
Are homeless people treated fairly?

## Section 3 : Suggestions for change in relation to services

***Aims of the discussion question:***

To identify suggestions for new services or modifications to existing services.

**General Question:**
**What, if anything, would improve services for homeless people in the area?**

What changes would you like to see made to the existing services (statutory or voluntary/ community) for homeless people in this area?
How could access to services be improved?
What would help to make services better for homeless people?

Are there any new services (statutory or voluntary/ community) that you would like for homeless people in this area?
What new services are required?
Where should they be located?
What would the ideal service (s) be like?

## Section 4 : Health promotion & health education

***Aims of the discussion question:***

To identify what is currently being provided in this

area & suggestions for developing health promotion & health education for homeless people through existing services.

### General Question:
### What could be done to promote the health & well-being of homeless people in the area?

*{Definition of health promotion – on flip chart}*

Health Promotion focuses on empowering people to enable them to increase control over and to improve their health & well-being. It takes account of physical, mental emotional, social, spiritual and environmental well-being & is concerned with addressing factors which impact on health & well-being.

Health promotion includes health education such as information & courses , but also

- ❏ advocating for & creating healthy public policy;
- ❏ ensuring that environments in which people live, work & interact promote health.
- ❏ enabling people to develop skills to empower them & improve their health & well-being;
- ❏ strengthening community action so that people are empowered to address the factors that impact on their well-being;
- ❏ and re-orienting services so that they are more health – promoting

What are the information needs of homeless people?

- What general information would be of use to homeless people?
- What health information would be of use to homeless people?
- Do homeless people have any difficulty accessing information?
- What is the best way to get information to the homeless people you work with?
- What changes would you like to see to the information & education service, for homeless people?

What, do you think, is currently being done to promote the health of homeless people?

- What is being done in your service?
- What is being done by other services?

What are the health promotion needs of homeless people?

- What areas need to be addressed to promote the health & well-being of homeless people?
- What are the gaps in relation to health promotion for homeless people?

How can the health promotion needs of homeless people be addressed?

How could the quality of life of homeless people be improved?

- How can existing work be improved?
- What else needs to be done?
- How can needs best be met?
- What would help in your own service?
- What can others do?
- What would be the most relevant form of health promotion?
- Of the areas you mentioned what would be the top 3 priorities?
- What would you like to see done in the next Year . . . 5 Years . . . 10 years?

### Ending

Wind the session down a few minutes before the specified time.

Give a brief resume of the main points & issues raised.

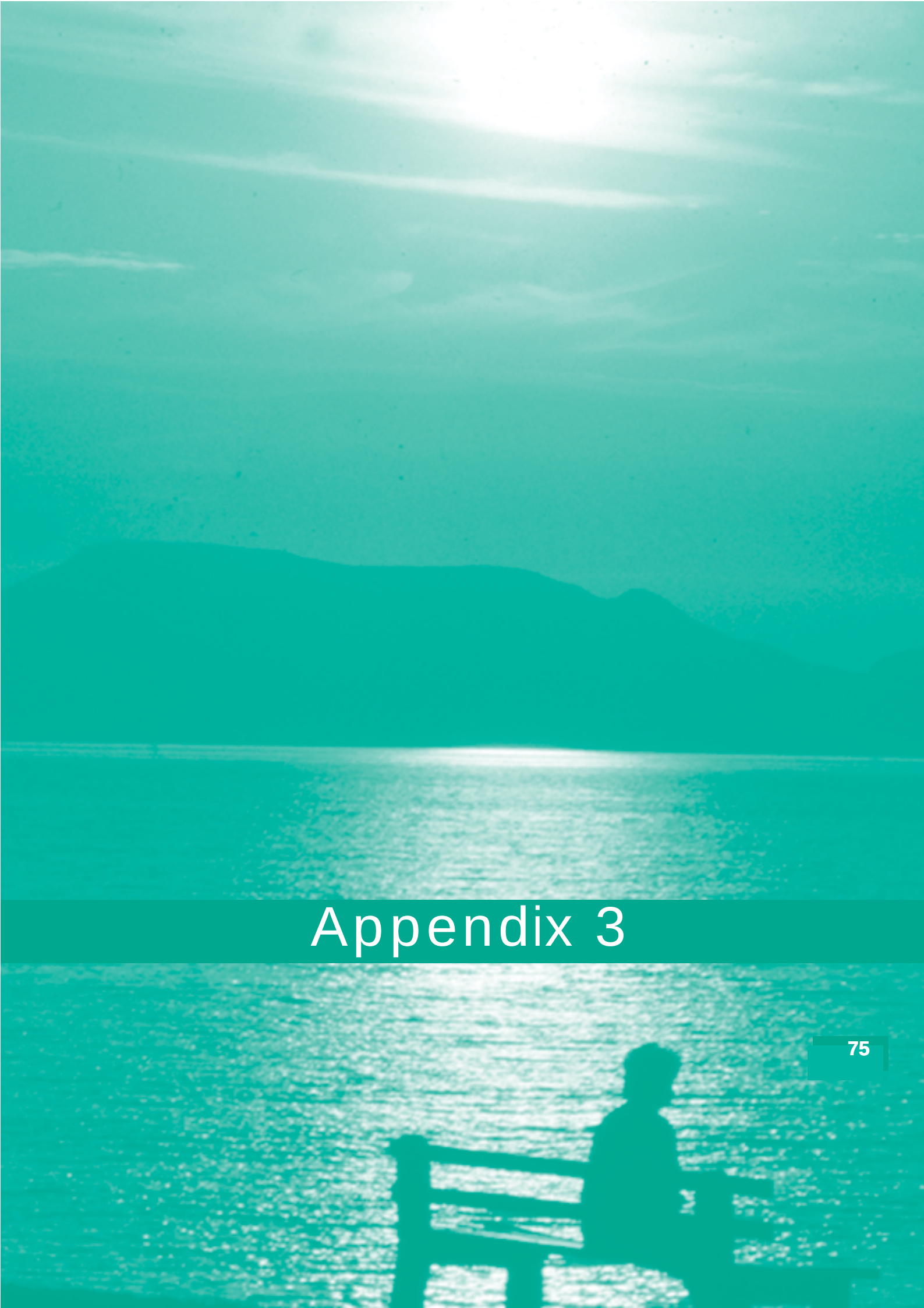
Ask: *Do you think we've missed anything?*

Thank everyone for their time an inconvenience and explain that the results will be very useful.

Re-iterate confidentiality and take the details of particpants who want a transcript or further information about the results of the study.

### Probes for use during focus groups

1. The silent probe
2. The 'go on I'm listening' probe
3. The 'journalists' probes e.g. When? Who? Where? What? How?
4. The immediate elaboration probe
   e.g. 'Can you tell me a bit more about that?'
   'What happened after that?'
   'What did you think / feel about that'
   'Why is that? Why do you think that is?'
5. The retrospective probe
   e.g. 'Can I take you back to something you said earlier . . '
   'You said . . . . ., could I ask you a bit more about that'
   'You said you felt _____ about . . . . why did you feel _____'



# Appendix 3

# Appendix 3 : Frequency of Use of Services

| | GP/ Doctor | | PHN | | Hosp A&E | | Hosp inpatient | | Dentist | | Optician | | Pharmacy/ Chemist | | Social Worker | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Every day | | | | | | | | | | | | | | | | |
| 2-3 times a week | 2 | 3 | | | | | 1 | 2 | 1 | 2 | | | | | | |
| Once a week | 9 | 14 | | | | | | | | | | | 12 | 19 | 4 | 6 |
| Once a fortnight | 8 | 11 | 1 | 2 | 3 | 5 | | | | | | | 7 | 11 | 4 | 6 |
| Once a month | 15 | 23 | | | 2 | 3 | | | | | | | 16 | 25 | 3 | 5 |
| Once every 3 mths | 13 | 20 | 4 | 6 | 7 | 11 | 9 | 14 | 1 | 2 | | | 9 | 14 | 3 | 5 |
| Once in 6 mths | 6 | 9 | 2 | 3 | 6 | 9 | 3 | 5 | 7 | 11 | 1 | 2 | 4 | 6 | 1 | 2 |
| Once a year | 4 | 6 | 3 | 5 | 6 | 9 | 7 | 11 | 13 | 20 | 10 | 15 | 3 | 5 | 3 | 5 |
| Less often | 7 | 11 | 6 | 9 | 22 | 34 | 28 | 43 | 27 | 42 | 24 | 37 | 8 | 12 | 9 | 14 |
| Never | 2 | 3 | 49 | 75 | 19 | 29 | 16 | 25 | 15 | 23 | 29 | 45 | 5 | 8 | 37 | 57 |
| Don't know | | | | | | | | | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 2 |

| | Addiction counselling | | Psychiatric services | | CWO | | Council | | SVP | | SIMON | | Cope | | Mayo Women's Support service | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Every day | | | 1 | 2 | | | | | 11 | 17 | 14 | 22 | 22 | 34 | 1 | 2 |
| 2-3 times a week | 3 | 5 | 1 | 2 | 1 | 2 | 1 | 2 | | | | | | | 2 | 3 |
| Once a week | 1 | 2 | | | 10 | 15 | 1 | 2 | | | | | 2 | 3 | 2 | 3 |
| Once a fortnight | | | 4 | 6 | 2 | 3 | | | | | | | 1 | 2 | | |
| Once a month | | | 4 | 6 | 6 | 9 | 3 | 5 | 1 | 2 | | | 1 | 2 | 2 | 3 |
| Once every 3 mths | 1 | 2 | 6 | 9 | 13 | 20 | 3 | 5 | 3 | 5 | | | | | | |
| Once in 6 mths | 2 | 3 | 3 | 5 | 2 | 3 | 7 | 10 | 6 | 9 | | | 2 | 3 | | |
| Once a year | 5 | 8 | 4 | 6 | 4 | 6 | 12 | 19 | 8 | 12 | 3 | 5 | | | | |
| Less often | 9 | 14 | 6 | 9 | 3 | 5 | 10 | 15 | 4 | 6 | 5 | 8 | 7 | 11 | | |
| Never | 44 | 68 | 36 | 55 | 24 | 37 | 27 | 42 | 29 | 45 | 35 | 54 | 23 | 36 | 49 | 76 |
| Don't know | | | | | | | 1 | 2 | 2 | 3 | | | | | | |

Chapter