

**PAST, CURRENT AND FUTURE PERSPECTIVES ON  
SERVICE RESPONSES TO THE HOMELESS STREET  
DRINKING POPULATION OF DUBLIN CITY CENTRE.**

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## **DECLARATION**

The contents of this thesis are entirely my own work and have not been submitted for any other purposes to any other University.

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## **ABSTRACT**

This research examines service responses to the 'homeless street drinking' population of Dublin City Centre, with the aim of carrying out a preliminary evaluation of the extent to which policy and practice is currently succeeding in addressing the needs of this specific group. The two substantive areas considered are the reality of the drinking problems faced by this cohort and an evaluation of current policy and management/practice of services to this group.

The main policy themes examined within the research were the homeless strategy, with its attempt to cross-cut/join-up the statutory and voluntary services, the extension of harm reduction ideas to street drinking and the growing awareness of the multiple needs of this group. A triangulation method was employed using a qualitative research approach. A literature review critically analysed current national and international thinking regarding this cohort and eight semi-structured interviews with key stakeholders were carried out. These methods enabled a comparison of cognitions and expectations of the interviewees while comparing them with current thinking in the wider spheres of influence.

The findings reveal that homeless street drinkers in Dublin City Centre are not, predominately rough sleepers. The inability of this cohort to comply with a range of services was identified as a significant issue, this was seen as one reason why homeless street drinkers are frequently 'houseless' but not 'roofless' i.e. often living in temporary accommodation. Significantly, the research revealed that poly-substance use and the risk of overdose are major risk factors for this cohort. That a new generation of younger people are using the streets to drink in and their use of licit and illicit substances is more prevalent. Notably, the research shows that co-morbidity is a major issue for this cohort, with psychiatric assessment identified as a major block to people experiencing co-morbidity. Finally, the research shows that in the last ten years a philosophical change has taken place which embraces harm reduction for this cohort. Along with this philosophical shift, the research found that although there is cynicism regarding 'higher policy cross cutting initiatives' improvements have been made in the service delivery to homeless street drinkers in Dublin City Centre.

## **INTRODUCTION**

Following almost seventy years of economic difficulties, bordering at times on major crisis, the economy of the Republic of Ireland has over the past ten to fifteen years been transformed, and the phrase 'Celtic Tiger' has been coined to describe the country's newfound prowess and success as a main player in the wider European economy. During this Celtic Tiger period an old phrase 'a rising tide lifts all boats' (originally associated with Sean Lemass, a Fianna Fail Taoiseach during the 1960s) has again been commonly used to suggest that economic growth will automatically benefit all citizens, and that there is no necessity for policy debate on the topic of social exclusion. However, the subjects of this research, homeless street drinkers, are clearly a group who live at the margins of Irish society and for whom, perhaps, relatively little has changed. Indeed, since soaring house prices in Dublin are one by-product of the current economic boom, it may well be that the difficulties experienced by people with alcohol-related problems and no fixed abode have been exacerbated in recent years.

The aim of the research presented in this thesis is to explore the extent to which, over the past decade, policy and practice has succeeded in identifying and responding to the needs of those people in Dublin City who may, however vague or unsatisfactory the term is, be described as homeless street drinkers. This overall aim may be sub-divided into two more specific aims: one is to find out how key stakeholders view or define this cohort whose problems are both complex and changing and the second is to find out how these same key stakeholders evaluate the current service response to this group of marginalised people for whom the Celtic Tiger is not an everyday reality.

The policy background to this research is one, comparable of course to that existing in other developed countries, where there has been a major emphasis at high-policy level on the importance of providing a 'joined-up' response to needs which are commonly described as 'cross-cutting'; that is, these needs cannot be adequately met from within any single sector of government but demand an integrated or coordinated response from a variety of governmental sectors. In relation to homeless street drinkers in Dublin, the cross-cutting primarily involves the local authorities who have statutory responsibilities for the provision of housing and the health authority (currently a single national Health Service Executive) which has responsibility for treatment service provision for those with alcohol-related problems. In addition to this obvious necessity to coordinate activities between these two major governmental sectors, there is an equal necessity to recognise that within these two large sectors there may be a lack of internal integration or coordination which may impact on service users; and yet another element of the 'joining-up' process involves the integration of these statutory services with the work of the voluntary or non-governmental organisations, which have always played a dominant role in service provision for homeless street drinkers. Over the past decade, the business of transforming Irish public sector management in line with 'New Public Management' internationally has been conducted under the banner of Strategic Management Initiative (SMI), and what is being explored here is the extent to which those most closely involved with homeless street drinkers believe that this top-down initiative has made any real impact on the quality of life of this group of people. Within the wider alcohol and drug service systems, there has also been considerable philosophical change, particularly in relation to harm reduction, and what needs to be explored here is whether or not this translated into a more flexible type of



service response for problem drinkers who have not traditionally been comfortable within service systems mainly designed for more socially stable clients.

The remainder of this thesis is structured over four chapters. Chapter one is a literature review which critically analyses literature on related areas. Chapter two is the methodology which describes how the research was carried out. Chapter three is the findings which outlines the results of the qualitative data gathered. Finally, chapter four is the discussion and conclusion which examines and considers the outcome of the research.

## CHAPTER ONE: LITERATURE REVIEW

The purpose of this literature review is to provide a theoretical framework for this study. The literature review is laid out so as to examine key themes impacting upon the lives of those people living a homeless street drinking lifestyle. The literature review will consider what constitutes a profile of a homeless street drinker, what issues are associated with this lifestyle, a review of policy impacting on homeless street drinkers, a review of conventional alcohol service systems and finally a review of literature related to new and innovative services.

A recent study of drug use among the homeless population of Ireland established the current disparity of problem alcohol use within this group. Specifically, that out of the total study population of 247, it was recorded that 48.6% scored as having an ‘Alcohol Problem (harmful/hazardous drinking)’ and living in Dublin. The other major urban areas Cork, Limerick and Galway also reported high levels of alcohol problems among their homeless population. However, Dublin clearly bore the brunt of the problem with 120 of the 171 individuals surveyed in Dublin recording an alcohol problem, equivalent to 70% of the local population surveyed (Lawless & Corr, (2005), p65).

Lawless & Corr also highlighted that within the findings of their research everyday levels of consumption of alcohol were high.

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

(Lawless & Corr (2005), p16).

The term ‘homeless street drinker’ has been coined to describe a marginalised person that drinks openly in the streets who by their very appearance would seem to stand out from the rest of society. Does homeless street drinker as a descriptive term do justice to the people to whom it is attributed? The first issue presented here considers who are homeless street drinkers?

## WHO ARE HOMELESS STREET DRINKERS?

### HOMELESSNESS IN IRELAND

The current legal definition of Homelessness in Ireland is covered under Section 2 of the Housing Act, 1988.

<i>Homeless persons for the purposes of this Act.</i>	<i>2. —A person shall be regarded by a housing authority as being homeless for the purposes of this Act if— (a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or (b) He is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources.</i>
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([www.irishstatutebook.ie](http://www.irishstatutebook.ie))

Put simply, people are homeless in Ireland if, in the opinion of the local authority, they have no accommodation they can realistically live in or remain in, or they are living in temporary accommodation of some type as they have nowhere else to go and they cannot afford to get their own accommodation.

In an attempt to further refine the definition across Europe over the last few years, the European Federation of National Organisations working with the Homeless (FEANTSA) has developed a European Typology for data collection on homelessness and housing

exclusion (ETHOS). This typology uses abstracts of existing legal definitions in the EU member states. ETHOS attempts to create a broad typology by using the housing, social and legal domains to classify homeless people according to their living situation.

<b><i>Ethos Definition</i></b>	
<b><i>Roofless</i></b>	<ul style="list-style-type: none"> <li>▪ <i>Rough sleeping</i></li> <li>▪ <i>Nightshelter</i></li> </ul>
<b><i>Houseless</i></b>	<ul style="list-style-type: none"> <li>▪ <i>Hostel/Temporary Accommodation</i></li> <li>▪ <i>Women's Shelter</i></li> <li>▪ <i>Asylum/immigrants centre</i></li> <li>▪ <i>Institutional release</i></li> <li>▪ <i>Supported housing</i></li> </ul>
<b><i>Insecure Housing</i></b>	<ul style="list-style-type: none"> <li>▪ <i>No tenancy</i></li> <li>▪ <i>Eviction orders</i></li> <li>▪ <i>Violence/Threat</i></li> </ul>
<b><i>Inadequately Housed</i></b>	<ul style="list-style-type: none"> <li>▪ <i>Temporary Illegal Structures</i></li> <li>▪ <i>Overcrowding</i></li> <li>▪ <i>Unfit for habitation</i></li> </ul>

(Cornerstone issue 25, (2005) p15)

#### DEFINING 'STREET DRINKER'

Defining 'street drinker' is complex due to the number of possible variables that may impact on an individual living a street drinking lifestyle; however, there are consistent traits that are core to the experience.

*A person, who drinks in public and at least in the short term, is unable or unwilling to stop or control his or her drinking. Most street drinkers have a long history of alcohol misuse. Street drinkers often drink in groups for companionship. The average street drinker is likely to be "a white unemployed man aged 35 or older; who is probably homeless and sleeping rough or in temporary accommodation; who may be alcohol dependent, certainly often drunk, and who may also be using controlled drugs; perhaps also suffering from psychiatric disorders of varying degrees of severity; often poor state of physical health; at risk of arrest for public drunkenness offences . . . and at risk of being the victims of assault."*

(Alcohol Concern, (2003) Factsheet 19: Street Drinking, p1)

The above definition encapsulates much of these core traits, further to this and due to the large quantity of alcohol consumed by this group the issue of increased risk taking behaviour is greater than in other groups. The Royal College of Psychiatrists describes the immediate effects of alcohol on an individual's inhibition as:

*the majority of individuals feel carefree and released from many of their ordinary anxieties and inhibitions . . . alcohol is in the true sense a depressant of the nervous system . . . The disinhibiting effects of alcohol may release suppressed feelings.*

(Bewley et al, (1986), p46).

Many homeless street drinkers lend money, share alcohol in drinking schools and use/deal in illicit drugs. It is these factors when mixed with the disinhibiting effects of alcohol, that means that any renegeing on agreements between those in such a group is often met with aggression, threats and actual violence, sometimes with tragic consequences. Seymour and Costello highlight the significant risk of arrest due to violent and other anti social behaviour while drinking in public areas.

*Almost two-thirds (of respondents) saying that the streets, parks and public places were the most common location for them to drink . . . . The only significant difference between the homeless on committal group and those previously homeless related to the location of drinking – only one third of those previously homeless compared to almost two thirds of those homeless on committal said they mostly drank in public places. The significance of this finding is that homeless people drinking in public areas are potentially at an increased risk of being arrested.*

(Seymour & Costello, (2005), p63)

This literature suggests that this is a group that are involved in increased risk taking behaviour that leaves the individual at risk of arrest and susceptible to violence. Due to the effects of alcohol on the individual, criminal, aggressive and violent behaviour within this group are defining features.

## STREET DRINKING AND HOMELESSNESS

Research has shown that not all street drinkers are homeless. Alcohol Concern highlights that not all street drinkers sleep rough. “*Contrary to popular opinion many street drinkers do not sleep rough. Surveys of street drinkers show that between half and two thirds live in temporary accommodation . . .*” (Alcohol Concern (2003), p1). Costello & Howley found similar results in Dublin, “Most people had used one or more of the hostels for homeless people in Dublin at some stage in their lives. For many the experience had been a negative one.” (Costello & Howley (1999), p25). However, of those that live in ‘Hostel/Temporary Accommodation’ high proportions do have experience of sleeping rough. Depaul Trust Ireland’s Aungier St Project - wet hostel reported that 84% of the total number of service users in 2004 had experience of sleeping rough. Of that number 75% slept rough for one month or more (Depaul Trust (2005), p6).

In view of the fact that a wet hostel is designed to target homeless street drinkers, this gives a snapshot of the rough sleeping history of the wider population of homeless street drinkers in Dublin. Similarly, Lawless & Corr highlighted that of those living in Hostel, B&B and Rough Sleeping scenarios. 74%, 63% and 71% respectively were recorded as having an alcohol problem (Lawless & Corr, (2005), p66). This offers insight into the high levels of alcohol problems within this group living in these situations and the transient nature of the group. It suggests a ‘revolving door’ scenario whereby homeless street drinkers experience difficulty in finding stable accommodation, moving between hostel/temporary accommodation and rough sleeping. Taking into account that only one fifth of an English study of street drinkers slept rough and two thirds resided in hostel/temporary accommodation (Costello & Howley (1999), p9). It is most likely that, in line with

FEANTSA typology, many of those individuals living in the ‘Roofless’ and ‘Houseless’ categories use the streets to consume alcohol in and around Dublin City centre.

#### DEMOGRAPHICS AND SOCIAL BACKGROUND OF THE HOMELESS STREET DRINKER

Due to Ireland’s limited racial-mix, street drinkers in Dublin are likely to be white, Irish, males, with a smaller proportion of white Irish females. An English study of street drinkers found that the ratio of men to women was 8:1 (Costello & Howley (1999), p9).

Lawless & Corr indicated that other races or ethnic groups are not a major issue within this or similar drug using groups in Ireland at present.

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

(Lawless & Corr, (2005), p.51)

At this time, the question of race or ethnicity is not a significant concern for this research.

The social background of homeless street drinkers includes those individuals who have come from troubled family backgrounds, institutional care, poverty and unemployment.

- *Common background characteristics among the homeless include adverse childhood experiences, minimal school and a history of unemployment.*
- *Poverty, unemployment and lack of affordable housing are all associated with homelessness and the breakdown of relationships; violence is an important precipitator of homelessness especially for women.*

(Cleary & Prizeman, (1998), p.5)

As Cleary & Prizeman demonstrate, there are defined routes into Homelessness. Homeless street drinkers are no different to other groups in this regard, notwithstanding their added burden of problem alcohol use.

#### ASSOCIATED CONDITIONS AFFECTING HOMELESS STREET DRINKERS

There are a number of well-documented issues associated with homeless street drinkers, such issues impact upon and compound their lifestyle, their choices and self-efficacy for change.

*Street drinkers are marginal to the general homeless population and suffer the additional problems caused by their alcohol dependence and life on the streets. They can suffer from psychiatric problems, such as depression, anxiety, anti social personality disorders as well as alcohol related psychosis. They also experience feelings of isolation and loneliness while living on the streets. They are at risk of ill health relating to excessive drinking, for example liver damage and heart disease as well as risks to health and safety from sleeping rough.*

(Costello & Howley, (1999), p.3)

There are a range of social, mental and physical problems experienced by people living a homeless street drinking lifestyle. Areas that may impact socially include aggressive irrational behaviour, family breakdown, isolation/loneliness, loss of inhibitions, increased risk taking, loss of self-esteem/purpose, restlessness and violence.

Symptoms relating to mental ill health that may be displayed by an individual living a homeless street drinking lifestyle include anxiety/unknown fears, blackouts, damage to the nervous system, depression/ mood swings, hallucinations, insomnia, nervousness, poor concentration and serious memory loss. Possible, common, diagnosis would include Epilepsy, Schizophrenia and alcohol related dementia i.e. Korsakoffs/Wernickes.



Physical health issues that may impact on an individual living a homeless street drinking lifestyle include, heart problems, deterioration of physical appearance, bowel and urinary issues, liver damage including cancer, nerve damage, nutritional issues, reduced resistance to infection, sexual health problems, stomach problems and other health issues.

Psychiatric and psychological issues listed above are possible co-existing issues for homeless street drinkers. Co-morbidity, also referred to as dual diagnosis, is common within this group. Psychiatric/psychological issues may arise through problem alcohol use or problem alcohol use may have arisen due to psychiatric/psychological issues. In Ireland people with psychiatric illnesses find themselves in a cycle of homelessness and mental ill health for four main reasons. Firstly, a person's access to psychiatric services is based upon where they come from rather than where they are now living. This is due to the "sectorisation" of psychiatric services into catchments areas. Secondly, many people who are mentally ill and homeless do not present for services. The community psychiatric system as presently organised essentially caters for compliant clients; non-compliant clients are largely ignored, some of them are drug and alcohol dependent. Thirdly there may be no services available to the homeless mentally ill. Fourthly, there is often no follow up after discharge from inpatient care and people fall between the gaps in service delivery. (McKeown, (1999), P.13-15). Whatever the individual's experience, the literature demonstrates that this group of people are some of the most difficult to work with. As Dr Fernandez, Director of the programme for the homeless in St Brendan's Psychiatric Hospital, Dublin, explains, "*The most difficult and deprived group of dually diagnosed individuals are those who abuse alcohol . . . and who also suffer severe psychiatric disorder.*" (Crowley, (2003), p.28). Lawless & Corr also found that problem drinkers in

the homeless population in Ireland were more likely to report having psychiatric concerns, even more so than their problem drug using counterparts.

*Problematic drinkers were significantly more likely to report psychiatric concerns than their non-problematic (drinking) counterparts. While not significant, problematic drug users were proportionally more likely to report psychiatric health concerns than their non-problematic drug using counterparts (50% vs. 40%)*

(Lawless & Corr, (2005), p.18)

Susan goes on to list the negative impact that problem substance use has on an individual with psychiatric issues.

*Substance abuse has been found to be associated with high rates of psychiatric symptom relapse and hospitalisation, medication and treatment non-compliance, aggressive and violent behaviour, criminal activity, poor money management, and loss of social support.*

(Susan A. et al, (2003), p.321-p.322).

The writer has found no reference to poly-substance use in literature relating to homeless street drinkers. Poly-substance use is the use of more than one licit or illicit drug. An individual may have a drug of choice such as alcohol, heroin, benzodiazepine, cocaine, etc. however when the opportunity presents itself the person may use other substances. Illicit drugs are readily available to people who are homeless e.g. benzodiazepine, opiates, amphetamines, cocaine and methadone. Where they are able to access them, homeless street drinkers are regular users of primary care services. Prescriptions are often the only interventions available to medical professionals, these drugs may also have a street value and may become a bartering commodity. Once out of the hands of the person they are prescribed for, they become part of the illicit drug market. Due to the increased risk taking behaviour of this group, there may be a greater potential for poly-substance use? If so there may also be an increased risk of overdose within the homeless street drinking population?

## NATIONAL POLICY

### ‘STRATEGIC MANAGEMENT INITIATIVE’ AND ‘DELIVERING BETTER GOVERNMENT’

In 1994 the Irish Government established the Strategic Management Initiative (SMI). As Butler explains this new initiative, “was heavily influenced by public management developments in New Zealand and Australia (and) was largely based on the view that the achievement of important public policy objectives frequently demanded a level of intersectoral collaboration.” (Butler S (2002), p.11). The objectives of SMI were to ensure that the public service would make a greater contribution to national development, be a provider of excellent services to the public and make effective use of resources. An important feature of SMI was that it would ensure that the public services would now address crosscutting policy issues through an organisational networking style of policy formulation. In February 1994, the Government established a coordinating group of Secretaries of Departments entitled the Implementation Group of Secretaries General. The purpose of the group was to consider the development of a strategic management process in the Irish Public Service, facilitate the preparation of strategy statements at the individual department level and oversee the allocation of a fund to assist departments to acquire expertise in strategic planning and organisational development. This group’s work led to the publication of ‘Delivering Better Government’ (DBG), which was published in May 1996. DBG was intended to give a clear pathway for the programme for change and modernisation. DBG expanded on the framework set out in SMI and outlined an extensive modernisation process for the Irish public service. SMI and DBG directly impacted on the development of such relevant policy initiatives as the National Drug Strategy Team, the development of Local Drugs Task Forces, the development of a National Alcohol Policy in

1996, the establishment by The Department of Health and Children of a Strategic Task Force on Alcohol in 2000 and the development of an integrated strategy on homelessness published in May 2000. This is not an exhaustive list of relevant policy; but as we can see, the impact of SMI and DBG was extensive on the formulation of policy for the drug, alcohol and homelessness sectors.

#### AN INTEGRATED HOMELESS STRATEGY

‘Homelessness: an Integrated Strategy’ was published in May 2000 by the Irish government. A strategy on homelessness prepared by a cross-departmental team, the strategy aimed to ensure that homelessness in Ireland would be tackled in a coordinated way, through the development of three-year action plans in each local authority area. Under the strategy, in conjunction with health boards and relevant voluntary bodies, each local authority is required to draw up and implement an action plan to tackle homelessness. Within this strategy it was acknowledged that the situation in Dublin was exceptional. It was accepted, that the Dublin homelessness scenario was a more long-standing and extensive problem than elsewhere in the country and accounted at that time for three quarters of the national homeless population. The report proposed:

*A Director for homeless services in the greater Dublin area will be appointed by Dublin Corporation. A new joint executive homeless service centre will be established to manage and coordinate the delivery of all services by both the statutory and voluntary agencies to the homeless in Dublin. This will have staffing from Dublin Corporation, the Eastern regional Health Authority and other agencies.*  
(Department of Environment (2000), p.56)

The Dublin based Homeless Initiative had submitted proposals for such a structure to the cross-departmental team in 1999. The Homeless Initiative had been established in late

1996 as a temporary consultative and administrative structure. Its aim was to build partnerships between organisations delivering homeless services, to identify gaps and make recommendations to address those gaps in services and to provide information for people experiencing homelessness.

The planning and delivery of homeless services was identified as an area of serious deficiency. It was this proposal to the cross-departmental team in 1999 and the publication of 'Homelessness - an Integrated Strategy' that led, in 2001, to the establishment of Dublin's Homeless Agency as the coordinating body of services to people who are homeless. The Homeless Agency took over the functions of the Homeless Initiative, which ceased to exist, and took on responsibility for the implementation of the Dublin action plan on homelessness. The current structure of the Homeless Agency includes a Board of Management and Consultative Forum. This structure includes representatives from as many relevant fields as possible to allow for consultation and a crosscutting approach to homeless policy making in Dublin.

#### RECENT SIGNIFICANT POLICY DEVELOPMENT IN THE DELIVERY OF PSYCHIATRIC SERVICES TO HOMELESS STREET DRINKERS.

On 4th August 2003 the then Minister of State at the Department of Health and Children Tim O'Malley, T.D. announced the establishment of an 'Expert Group on Mental Health Policy'. Chaired by Professor Joyce O'Connor, the Group prepared a new national policy framework document for the mental health services 'A Vision for Change'. Published in February 2006, 'A Vision for Change' replaced the existing policy document, 'Planning for the Future', which was published in 1984. 'Planning for the Future' had, among other

areas, promoted the establishment of the sectorisation of psychiatric services, which causes a block to psychiatric services for homeless street drinkers (McKeown (1999) p.13-15).

‘A Vision for Change’ addresses two significant areas for this research ‘Mental Health Services for Homeless People’ and ‘Mental Health Services for People with Co-morbid Severe Mental Illness and Substance Abuse’.

*Recommendations:*

*Mental Health services for homeless people*

1. *A data base should be established to refine the dimension and characteristics of homelessness and analyse how services are currently dealing with it.*
2. *In the light of this information, scientifically acquired and analysed, make recommendations as to requirements and implement them.*
3. *The Action Plan on Homelessness in Dublin should be fully implemented and the statutory responsibility of housing authorities in this area should be reinforced.*
4. *A range of suitable, affordable housing options should be available to prevent the mentally ill becoming homeless.*
5. *The CMHT team with responsibility and accountability for the homeless population in each catchment area should be clearly identified. Ideally this CMHT should be equipped to offer assertive outreach. Two multidisciplinary, community-based teams should be provided, one in North Dublin and one in South Dublin, to provide a mental health service to the homeless population.*
6. *All community mental health teams should adopt practices to help prevent service users becoming homeless, such as guidelines for the discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services.*
7. *Integration and coordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged.*

(Department of Health and Children (2006) p145)

These recommendations were designed by the ‘Expert Group on Mental Health Policy’ to stop people becoming homeless in the first instance and to ensure that when people do become homeless that there is responsibility and accountability within mental health services.

Significantly 'A Vision for Change' states clearly that addiction does not fall within the remit of the mental health system.

*The major responsibility for care of people with addiction lies outside the mental health system. . . . The responsibility of community mental health services is to respond to the needs of people with both problems of addiction and serious mental health disorders.*

(Department of Health and Children (2006) p146)

This is an important departure as historically in Ireland psychiatric services have played a key role in the delivery of services to those experiencing problem substance use i.e. detoxification and rehabilitation. However 'A Vision for Change' does see a clear role for the mental health system in the delivery of services to those people experiencing co-morbid problems and makes clear recommendations.

*Recommendations:*

*Mental health services for persons with co-morbid severe mental illness and substance abuse problems*

- 1. Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems.*
- 2. General adult CMHTs should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem.*
- 3. The post of National Policy Coordinator should be established to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol abuse and their linkage to mental health services.*
- 4. Specialist adult teams should be developed in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder.*
- 5. These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service users and referring adult CMHTs.*
- 6. Two additional adolescent multidisciplinary teams should be established outside Dublin to provide expertise to care for adolescents with co-morbid addiction and mental health problems. This provision should be reviewed after five years.*

(Department of Health and Children (2006) p149)

## CARE AND CASE MANAGEMENT

‘A Vision for Change’ advocates for a care and case management model.

*Service users with co-morbid mental health and substance abuse problems respond well to case management, and use of multi-profession teams. Programmes for co-morbid individuals should have a defined structure, a clear target and a minimum treatment period of three to six months.*

(Department of Health and Children (2006) p146)

This is in line with two recent higher level policy reports which have championed the care and case management model in relation to this cohort. The ‘Review of the Implementation of the Government’s Integrated and Preventative Homeless Strategies February 2006’ states that care and case management is a crucial issue in addressing the needs of homeless people.

*the development of a case management approach to addressing the needs of homeless individuals must be a critical objective. This approach should be based on key workers linked to a base of core services and specialist health services that can be accessed, depending on the individual’s unique needs.*

Fitzpatrick, (2006) p.15

The ‘Mid term review of the National Drug Strategy 2001 – 2008’ also refers to care and case management under Action 47, specifically, “*To base plans for treatment services on a continuum of care model and key worker approach to provide a seamless transition between the different phases of treatment.*” (Dept of Community, Rural and Gaeltacht Affairs 2005 p.11)

In Dublin local policy initiatives regarding care and case management have begun to address this issue. Significant inroads have been made in establishing this model of working. Most importantly a common understanding of what is care and case management has been reached as outlined by Eustace & Clarke in ‘Care & Case Management: Assessment of the Homeless Agency’s Model 2005’.



*While there are many different definitions of care and case management there appears to be general agreement that care management involves the co-ordination of services at management and administrative level while case management involves the implementation of care management policies at client level and the delivery of individually, tailored care plans.*

(Eustace & Clarke 2006 p.16)

It is clear that a care and case management approach offers a joined up interagency working model, at a policy and service level, which would have positive benefits for homeless street drinkers.

## CONVENTIONAL ALCOHOL SERVICE SYSTEMS

*Advocates of the so-called 'disease concept' of alcoholism, which became increasingly accepted internationally from the 1930s onwards, were intent on putting a scientific gloss on the management of alcohol problems, thereby taking it out of the realm of moralism. Although the disease concept reduced the moralistic tone of policy and practice in relation to drinking problems, it did so largely through its advancement of the notion of alcoholism as a specific disease, recovery from which demanded lifelong abstinence. Throughout most of the twentieth century, therefore, services for homeless people who had alcohol-related problems were dominated by abstinence models of intervention: clients were usually not allowed to bring alcoholic beverages into 'dry' residential facilities, they were counselled directly to abstain, and medically-based services were primarily aimed at detoxification.*

(Butler S (2003), p.8)

In his article Butler succinctly explains the main thrust of the development of services to those people experiencing problem alcohol use from 1930s onwards. The development and the influence of the disease model throughout this period effectively meant that for all those suffering problem alcohol use the solution was a one size fits all i.e. medical detoxification followed by a period of rehabilitation and counselling. If you did not wish to become abstinent then you were left to your own devices until you hit 'rock bottom'. Once

at 'Rock Bottom' you either worked towards the goal of abstinence or received little or no assistance.

From the 1980s onwards two key events led to a shift towards a debate regarding a public health approach in Ireland and the introduction of harm reduction interventions. Firstly, the publication of 'Planning for the Future' a landmark policy document on future delivery of psychiatric services in Ireland. Critical of the disease model the report called for a health promotion approach to problem substance use. Secondly, the HIV and Aids crisis in the mid 1980s led to the eventual introduction of harm reduction measures i.e. needle exchange and Methadone maintenance. These were clearly a shift away from the former more prevalent disease model of thinking.

#### DIFFICULTIES IN APPLYING CONVENTIONAL ALCOHOL SERVICE SYSTEMS

To access conventional models of alcohol services i.e. medical detoxification, rehabilitation and counselling requires motivation. If we consider Prochaska and DiClemente's 'Stages of Change Model' many homeless street drinkers could be described as being chronically in 'Contemplation' and 'Preparation' (Miller & Rollnick (1991), p.15). This group of people are often aware of their actions regarding their level of drinking and would often talk about and consider change. However, as a consequence of their social backgrounds, support networks and opportunities for change the individual rarely makes the move towards positive change or 'Action Phase', without intense support. Tailoring a package around the individual as opposed to requiring the individual to fit into conventional treatment methods is the desired approach. Susan et al describes a successful model of working with the co-morbidly diagnosed that addresses these issues.

*. . programmes use multidisciplinary teams consisting of case managers, addiction counsellors, and residential staff to deliver mental health, substance abuse treatment, and housing services. Many of these programmes use a harm-reduction philosophy in which substance use and relapse are tolerated and expected, but are not considered grounds for terminating treatment.*  
(Susan A. et al, (2003), p.322).

McKeown also describes building services around the person as a crucial feature, “This will involve outreach and street work as well as constant follow up . . . this group needs an assertive, outreach approach which demands a specialised team ”, (McKeown (1999) P.21)

#### NEW AND INNOVATIVE ‘EVIDENCE BASED PRACTICE’ SERVICES

There are a number of new, innovative and evidence based best practice services for homeless street drinkers in Dublin City Centre that are far removed from the ‘disease model’ only type approach. They operate at a number of levels, ideologically they are inclusive of harm reduction and abstinence based services and include approaches such as brief solution focused therapies and models of working that address problem substance use through Health and Social systems i.e. ‘Community Reinforcement Approach’.

#### ABSTINENCE BASED SERVICES

In recent years a significant development in alcohol detoxification in Dublin City Centre was the Health Service Executive funded Dublin Simon Community - Alcohol Detoxification Unit. Opened in April 2003 and based on the ‘Rugby House Crisis Centre’ in London, the Dublin Simon Community Alcohol Detoxification Unit is a 9-bed unit for homeless street drinkers. Service users are referred and a decision for admission is made based on need and availability of beds. Service users may arrive intoxicated. They are

then medicated and monitored closely until their Blood Alcohol Content returns to zero. Once this is achieved they may mix with other service users and enter into a programme of treatment. The maximum length of stay at the Dublin Simon Community Alcohol Detoxification Unit is three weeks. Work to ensure that the individual has a positive move-on option is core to the work during these three weeks. Move on options include the in-house Dublin Simon Community rehabilitation unit, other voluntary organisation run rehabilitation units, self-contained accommodation or a return to previous situation (Dublin Simon (2003), p.5). A return to the service users previous situation may include returning to a 'roofless' or a 'houseless' situation. Although, this may not be desirable or indeed make sense to some, it may have been the intention of the individual to have a break from drinking and from a harm reduction perspective this is seen as a legitimate goal.

## PSYCHIATRIC SERVICES

*At present in Ireland dual diagnosis is not clearly understood as a concept nor is it formally recognised in mainstream addiction and mental health services.*  
(MacGabhann L et al, (2004), p.91)

Susan et al describe how structurally services must be provided in a seamless manner i.e. addiction, psychiatric, housing and social welfare services working together. Ideally, provided by one agency or integrated treatment service (Susan et al (2003) p321). Where this is not possible, as identified in "A Vision for Change", a case management approach should be employed and a lead agency should be identified.

Currently in Dublin City Centre there is one dedicated psychiatric team for people who are homeless. The Assertive Community Outreach Evaluation Services (ACCES) Team provides a community mental health service to those who are mentally ill and homeless.

The team provide direct mental health care to those experiencing homelessness in the South Western Area of Dublin. Dually diagnosed patients are stated as one of the team's areas of service provision.

## HARM REDUCTION

At a policy level Lawless & Corr advocate for all substances to be treated within harm reduction as well as abstinence policy options.

### *Policy implications*

6. *Harm reduction should be understood to include all substances both licit and illicit. Given the profile of homeless drug users, it is important that a targeted alcohol harm reduction strategy for members of the homeless population is promoted. As with drug use, abstinence may be unacceptable as a goal for the individual and in such cases, it is necessary to implement strategies which focus on moderation in use and reducing alcohol related harm.*

(Lawless & Corr, (2005), p22)

## WET ACCOMMODATION

'Wet accommodation' is a term used to describe hostel/temporary accommodation or supported housing that allows the consumption of alcohol on the premises. Internationally this concept is not new, at the turn of the century "A Feasibility Study on the Provision of Accommodation for Homeless Street Drinkers in Dublin City", by Costello summarised the provision of 5 projects in London providing 477 beds to homeless street drinkers. This report recommended that policy makers and service providers for this group of people should return to wetter options.

Butler gives us an insight into the history of wet accommodation provision in Ireland:

*The first significant move away from (the) abstinence approach to working with homeless problem drinkers was that of the newly created Simon Community during the 1960s. Simon recognised that many clients were unprepared for the radical personal change involved in an alcohol-free lifestyle & that services which were aimed exclusively at achieving abstinence were unacceptable to & alienating of significant numbers of potential clients.*

(Butler S (2003), p7-8)

However, by the nineteen-nineties there were no wet accommodation options in Ireland. Indeed, at some point Dublin Simon Community had developed ‘no drink rules’, (where certain service users could not access the service while under the influence) and ‘drink curfews’ (where other service users who had consumed alcohol could not enter the shelter until 18.30) (Foy S, (2004), p2) as policies within their hostel accommodation.

In December 2002 Aungier Street Project – wet hostel was opened. This was a low threshold harm reduction project for homeless street drinkers, funded through the Homeless Agency and provided by Depaul Trust Ireland. December 2002, also, saw the opening of a wet hostel in Limerick provided by ‘Tír an Droichead’. Following on from this, in January 2004 Dublin Simon Community opened a wet room at their hostel accommodation in Harcourt Street.

The concept of opening the doors and allowing people to drink themselves into a stupor without intervention is not desirable. Therefore, allowing service users to consume alcohol on the premises is not the only distinctive feature of wet accommodation provision.

*. . . a high degree of health care, a strong keyworking system, an adequate choice of move on options and its ability to link in with relevant agencies at an early stage are equally important.*

(Costello L, (2000), p 4)

Harm reduction should be proactive in its nature, creating a rapport and a beneficial relationship with the service user, engaging in keyworking to agree realistic goals, managing difficult behaviour and addressing physical health, psychiatric health and emotional issues as they arise are all necessary in the provision of wet services. Drinking should only take place in designated areas; the provision of dry spaces to provide options for service users to abstain or reduce their drinking is an essential element of wet accommodation (Costello (2000) p.40).

In Ireland wet accommodation is currently a popular service option for homeless street drinkers. In Belfast, Stella Maris Hostel was reopened in 2005 as wet accommodation and Dublin City Council are currently building a purpose built wet project designed as long term supported housing for street drinkers, both delivered by the Depaul Trust Ireland. Also, Cork City Council plans to establish its first dedicated wet shelter, or gateway project, in Leitrim Street, which would be run by Cork Simon Community. Finally, local homeless strategies around Ireland and other social policy strategic plans tend to include the future provision of 'Wet Accommodation' services. For example, the Lord Mayor's Commission on Crime and Policing stated:

*The Commission believes that it needs to deliver on the recommendations of the Homelessness Strategy of Dublin City Council to provide 8 wet hostels and indoor drinking spaces for these chronic alcoholics.*

(The Lord Mayor's Commission on Crime and Policing (2005) p.43)

## MANAGED ALCOHOL PROGRAM

From a harm reduction perspective, the provision of a safe place to consume alcohol is an effective way to address behaviours and health issues of this service user group i.e. managing difficult behaviour, reducing violence, encouraging service users to reduce their drinking, re-establishing family contacts, etc. The Aungier St project in Dublin City centre is clearly intended to achieve these goals. In Canada, an attempt has been made to build on this concept of working with those experiencing problem alcohol use. In a collaborative approach, the Inner City Health Project, University of Ottawa, the Department of Medicine, Ottawa Hospital has developed a Managed Alcohol Program (MAP) 15-beds based in a homeless shelter in Ottawa, Canada. The principal is the same as prescribing heroin to problem heroin users. An obvious advantage with this intervention is that alcohol is a licit drug and does not raise as controversial a moral debate as the prescribing of heroin.

A group of potential participants, homeless street drinkers, were identified and referred by hostel staff, police or community workers familiar with their cases. The criteria for the potential service users included having a history of chronic homelessness, being diagnosed as having severe 'alcoholism' (according to DSM-IV diagnostic criteria for alcohol abuse), showing tangible evidence of harm to self and community and having a history of failure within, or refusal of, existing abstinence based services. Entrance to the programme was arranged with the agreement of the service user, shelter staff and management.

The 15 beds were housed within in an existing hostel; ensuring basic needs of housing and food were met. Participants contribute \$100 of their \$112 social welfare payment towards the cost of alcohol. A keyworker was employed to provide case management i.e. manage service users, provide practical support with daily living activities, help complete



applications for social welfare benefits, accompany them to medical appointments and regularly dispense medication.

Significantly alcohol was managed under a clinical regime as outlined below:

*Participants were given up to a maximum of 5 ounces (140ml) of wine or 3 ounces (90ml) of sherry hourly, on demand, from 0700–2200, 7 days per week. Medical care was provided 24 hours per day by nurses and 2 physicians associated with the project, with daily nurse and weekly physician visits.*  
(Podymow T, et al, (2006), p45)

Nurses offered medical support 24-hours per day and 2 General Practitioners associated with the project visited weekly and medical records were kept on a secure internet-based system.

The outcomes of the MAP included; participants who typically drank 46 drinks a day before the program dropped to approximately eight drinks a day during the program, the number of emergency room visits fell by 36% and the number of encounters with police were effectively halved, falling by 51%.

## SUMMARY OF LITERATURE REVIEW

This literature review has given credence to the perception of the homeless street drinker as someone who is often dishevelled, emaciated, beaten and bruised, raucous and who may seem aggressive or intimidating. However, their appearance and actions gives little insight to the complicated underlying issues that these individuals suffer. The evidence clearly demonstrates that as a descriptive term or label 'homeless street drinker' does not do justice to the people to whom it is attributed and that there is a hierarchy of vulnerability within this group of people based on varying social, physical health and mental health needs.

It is also clear that homeless street drinkers are not predominantly 'roofless' they are often 'houseless' and reside in temporary housing situations. They live transient lifestyles often having to move regularly between sleeping rough and temporary housing options. They frequently suffer with co-morbidity issues and suffer related physical health issues. Their increased risk taking behaviour leaves them at risk of aggression, bullying, violence, arrest, infection and death.

The literature review has demonstrated that the multiple needs, unstable housing and problem alcohol use that cause a person to live a homeless street drinking lifestyle are intertwined. Due to their multiplicity these needs are difficult to respond to and a successful response would require social policy, economic policy, health policy and pragmatic service interventions. In Ireland, at a high policy level, the SMI was established to address a variety of complicated issues at a national level. This research is intended to find out if the SMI or any resulting local policy structures are perceived to have been successful in impacting on service delivery to homeless street drinkers in Dublin City Centre.

## **CHAPTER TWO: METHODOLOGY**

A study of service responses that evaluates the effectiveness of service provision would require the inclusion of a longitudinal study of outcomes of interventions for homeless street drinkers. It is not the purpose of this study to do a complete evaluation of the effectiveness of service responses. Instead, this research is intended to give a preliminary process evaluation of the effectiveness of service delivery from the perspectives of key stakeholders.

The methods employed in this research included:

- A literature review.
- Semi-structured qualitative interviews with policy makers within this arena.
- Semi-structured qualitative interviews with consultant psychiatrists working with this cohort.
- Semi-structured qualitative interviews with senior managers of homeless services.
- A semi-structured interview with a person who has lived a homeless street drinking lifestyle and who has life long experience of the service responses to this issue.

## CONSTRAINTS

As resources hindered this research in terms of time and money, a triangulation approach was employed. Triangulation is a methodological approach which provides the opportunity to verify findings from different perspectives and which reduces the risk of partial or biased findings. As Bell explains the cross checking process verifies the reliability of a study.

*Cross-checking the existence of certain phenomena and the veracity of individual accounts by gathering data from a number of informants and a number of sources and subsequently comparing and contrasting one account with another in order to produce as full and balanced a study as possible.*

(Bell J, (1993) Doing Your Research Project, P102)

## LITERATURE REVIEW

The literature review for this research involved the critical analysis of local, national and international policy documents. Other literature critically analysed included; internal documentation from the various service providers; documents which define/understand the drinking problems of this group and explain current thinking on the use of alcohol within this group; literature that considers current national and international models of best practice to address this behaviour.

## DATA COLLECTION

To understand how we have reached the current status quo concerning service responses to this group of people, it was necessary to interview a sample of those people with responsibility for the co-ordination, funding and delivery of services to the homeless street drinking population of Dublin and to interview someone with first hand experience of receiving these services.

## PARTICIPANT SELECTION

Current and previous policy makers, with responsibility for current policy and future policy in the provision of services to homeless street drinkers, interviewed included:

1. The Former Administrative Director of the 'Homeless Initiative' October 1996 to December 2000 and 'Homeless Agency' from December 2000 to January 2005. Who was responsible for the responses to and co-ordination of services to the homeless population of Dublin during this period.

For coding purposes this person was referred to as 'Policy Maker 1'

2. The current Director of the 'Homeless Agency', who is responsible for responses to and co-ordination of services to the homeless population of Dublin.

For coding purposes this person was referred to as 'Policy Maker 2'

Senior managers of significant voluntary agencies responsible for current service provision and the future vision of service delivery to homeless street drinkers, interviewed included:

3. The Director of Services of Dublin Simon Community

For coding purposes this person was referred to as 'Voluntary Services Manager 1'

4. The Director of Operations of Depaul Trust Ireland

For coding purposes this person was referred to as 'Voluntary Services Manager 2'

Consultant Psychiatrists interviewed included:

5. A Consultant Psychiatrist, specialising in substance misuse, based in Trinity Court Treatment Centre.

For coding purposes this person was referred to as 'Consultant Psychiatrist 1'

6. The Consultant Psychiatrist, specialising in working with the homeless mentally ill, based in the Assertive Community Outreach Evaluation Services (ACCES) Team under the umbrella of the Homeless Agency.

For coding purposes this person was referred to as 'Consultant Psychiatrist 2'

The General Practitioner interviewed:

7. The Principal General Practitioner in a North Inner City Dublin practice. The practice offers satellite services to drug services, food centres, day centres and homeless hostels including the wet hostel.

For coding purposes this person was referred to as the 'General Practitioner'

Service User:

8. A user of services to homeless street drinkers in Dublin City Centre for the last 30 years, this service user has detailed personal knowledge of the homeless, addiction and psychiatric services. Recently successfully settled into appropriate accommodation, the service user had also, until recently, held a governance position on the Board of Management of a homeless charity in Dublin.

For coding purposes this person was referred to as the 'Service User'

#### INTERVIEW DESIGN

The interviews were semi-structured with eight or nine questions for each interviewee. The questions were constructed around key subject matter as identified through the literature review. These were drafted to cover specific themes and designed to allow the researcher the opportunity to probe the interviewee on interesting and relevant topics. Bell describes how the unstructured style of interview can reap benefits, "Unstructured interviews centred round a topic may, and in skilled hands do, produce a wealth of valuable data." (Bell (1993) p.138). The intention of the researcher was to ensure that as much information as possible was gleaned by having structure and purpose, while allowing the flexibility of the

unstructured interview approach to get even more valuable data out of the interviewees. Interviews were recorded on a Dictaphone and transcribed for analysis at a later time.

#### EXTRAPOLATION OF DATA

To extract the findings, the researcher immersed himself in the qualitative data of over 30,000 words of transcribed data created by the eight interviews.

*the first step in any qualitative data analysis is for the researcher to become immersed in the information that he or she has gathered. The main instrument that the researcher possesses is his or her capacity to enter the lived experience of the person or group being studied*

(McLeod (1994) p.89)

The key subject matter as identified through the literature review was used as themes to code the data.

*Systematically working through the data, assigning coding categories or identifying meanings within the various segments/units of text*

(McLeod (1994) (p.90)

This enabled the researcher to present his findings in a logical and methodical manner, this was essential considering the amount of rich data received and the complicated nature of the subject.

## CHAPTER THREE: FINDINGS

As previously discussed, the aim of the empirical research carried out for this thesis is to explore the views of a range of stakeholders - policy makers, service managers and clinicians - as to how the needs of homeless substance misusers were identified and responded to by the various human service systems which deal with this group. All of the respondents participated fully. The responses received were impassioned and emphatic, to the point where some respondents requested that the researcher remove the strong language that they had used. Having analysed the transcribed data, the findings are presented in this chapter under a number of headings which reflect the main issues emerging from the qualitative interviews. The first issue presented here deals with the fundamental question of who these clients are, or at least how they are perceived by the respondents.

### A PROFILE OF HOMELESS STREET DRINKERS IN DUBLIN CITY CENTRE

Voluntary Services Manager 1 and Voluntary Services Manager 2 described the profile of people that they would be housing as mainly older men with a smaller proportion of women presenting.

*Predominantly male and over 35.*  
(Voluntary Services Manager 1)

*A brief profile would be mainly men in their forties presenting with a long-term history of street drinking, drinking in groups, drinking around the city centre, a lot of street drinkers would be socially isolated from families. Probably 15% are women presenting at the wet hostel at any one time.*  
(Voluntary Services Manager 2)

The type of people that these voluntary organisations are housing across their services would indicate that the needs of this vulnerable target group as identified in the late 1990s



are now being addressed. Respondents indicated that women remain in the minority as Voluntary Services Manager 2 outlines approx 15% of the population presenting at the wet hostel are women. The Service User gave an insight into the history and dynamic of the women that continue to drink and sleep rough on the streets of Dublin City Centre.

*Women would tend to drink in the company of men, if there were five men there could be just one woman in their company.*

*A relatively small number now; years ago a lot of them would have been travelling women. I used to drink in the company of a lot of travelling women. Many of the travelling women at that time were sleeping out and we'd drink together, but not so much now.*

(Service User)

The stereotypical older bearded man is less common on the streets of Dublin than ten years ago. This is due to those people living this lifestyle either changing their lifestyle, being successfully settled in the community in supported housing options that tolerate their behaviour or dying as a result of their lifestyle. As the Service User explained:

*Just an awful lot have died off and a lot of them that would have been typical street drinkers are in somewhere now, including myself.*

(Service User)

Younger people, i.e. under 35 year olds, were identified as a group of concern with increasing poly-substance use issues. Their progression paths into their alcohol and drug using career are varied and this issue is discussed later in the findings. However, on a purely superficial level this younger group is harder to identify as they are often better dressed and cleaner than their predecessors.

*I saw one guy taking out his can and he didn't look like a street drinker, he was well dressed. Most of them would be very clean. I have seen how they kind of hide away from it now, they try not to expose themselves.*

*You will still see a few lads around town and you know exactly by looking that they're a street drinker. With their bottle in their hand they wouldn't care who sees them.*

(Service User)

So the archetypal homeless street drinker is a less common sight in Dublin City Centre and a new breed of younger alcohol dependent individuals is using the streets to drink in. However, this does not mean that the new breed is less vulnerable or at less risk. The General Practitioner described how members of this group were increasingly presenting with multiple needs.

*The profile of this particular group we're getting is of people with multiple-complex social and medical problems. It's very rare to find someone with one single problem, say an addiction problem or a medical problem.*  
(General Practitioner)

Violence was accepted by the Service User as part of the culture of street drinking, although the rationale for and the level of violence displayed was unclear.

*We'd argue with each other over something, "you pissed off yesterday, I was dying for a drink and you didn't get us a drink", we usually let them back into our company. It would be an argument, someone might get a clout but that would be it. We're not talking about heavy violence. There's no knives pulled or someone getting stood on the head, not unless someone had done something really wrong.*  
(Service User)

Violence does occur and there is clearly an acceptance of 'a clout' with regard to renegeing on a drink or the price of a drink. From the researchers 'insider status', experience of these arguments and/or level of violence is a daily occurrence. Therefore, the findings of this research would concur with the literature review that a degree of violence is common place within the group of homeless street drinking population in Dublin City Centre.

Violence from outside of the homeless street drinking group was of more concern to the Service User and was the reason that the Service User took to sleeping rough in well hidden places and ultimately his move away from sleeping rough.

*Violence is a real issue for anyone around my age (52) that is their fear. They won't sleep in a doorway for the fear of being attacked from people outside their group. Normally, it would be people who are homeless or living in a hostel just wandering around in gangs. We had a problem in Crosscare Lane, there were three or four lads that used to come up there every night and mug the people. They were mugging Danny. I got annoyed and went over; one of the guys hit me with an empty vodka bottle on the head. Crosscare wouldn't let me in that night they said I needed stitches and sent me up to the hospital. These guys are armed with their empty bottles and one guy had a small bar, they came prepared. They were doing it on a regular basis to the lads sleeping on the streets.*  
(Service User)

This susceptibility to violence, whether from within their own group or otherwise, is clearly one of concern. The physical injuries, which are received through violence, further compounds the health needs of homeless street drinkers increasing the need for medical and psychiatric intervention.

#### POLY-SUBSTANCE USE AND THE RISK OF OVERDOSE

This research has found that poly substance and the risk of overdose are significant areas of concern. The research shows that the lines between alcohol and drug issues increasingly intersect. The policymakers, the practitioners and the service user interviewed have concurred on this issue. This is considered a new phenomenon in this group and it has only recently been acknowledged by professionals working in the field as an issue. Policy Maker 1 identified that poly substance use and the risk of overdose was not a concern when planning and designing services for this cohort in Dublin City Centre in the late 1990s. This explains why the services established for this cohort between 2002 and 2003 focused upon alcohol i.e. a wet house and a residential alcohol detox unit.

*Poly substance use and the risk of overdose was not a concern at the beginning. It was only when people began to move in and were more under scrutiny that it emerged that people weren't just drinking and that there were other substances involved. I'm not sure that services and planners were aware of that. Before you had them captive in a shelter, they were on the street. So unless somebody was doing ethnographic research and studying what they were doing on the street you wouldn't have known. There were a lot of assumptions made about the type of people who were street drinkers. It was only as time went on and only as they were in a shelter that it was possible for people to see that it wasn't as simple as people had imagined.*

(Policy Maker 1)

As Policy Maker 1 highlighted, the issue of poly substance use and the risk of overdose became more apparent in the last five years, since new services have been established in Dublin City Centre. Policy Maker 2 concurred with Policy Maker 1 on this issue:

*They would be critical issues in terms of the delivery of services right across the board from the specialist services that are more targeted towards that group of individuals to general services on the whole in responding to the needs of people who present.*

(Policy Maker 2)

The Service User indicated that homeless street drinkers could easily forget what drug they had taken and when intoxicated put themselves at serious risk of overdose:

*I know a lot of people who would drink and take tablets. In the morning they would be too sick to have a drink and they might have a librium or a valium to steady up. They would forget and take more and some have overdosed. The danger of overdosing is high; the risk is forgetting. It wouldn't be deliberate.*

(Service User)

The Service User also raised concern regarding the behaviour of younger people:

*For lads my age alcohol would be the drug of choice. More young people would dabble in poly-drug use and drink.*

(Service User)

Again, here the Service User was differentiating between the archetypal homeless street drinker and a new group of younger people drinking and using other illicit substances. The

notion that alcohol and prescribed drugs is acceptable, while alcohol and illicit drugs is unacceptable is common within the homeless street drinking cohort.

The voluntary services managers within the homeless sector also identified poly substance use and the risk of overdose as an area of concern.

*Up to 70% of people going through the Harcourt Street emergency shelter are rough sleepers. 320 individuals went through Harcourt Street last year. Our statistics would show circa 70% of those people would have alcohol and/or drug use issues. I think we all take tremendous precautions, we had 2 services users die in the last year due to drug overdoses in the shelter and there would be a lot more people that we would have concerns for. There would have been 2 or 3 people in the shelter in the last year that had drug overdoses somewhere else.*

(Voluntary Services Manager 1)

*They are very important issues; it is always an ongoing issue. There is always the underlying issue that if people can't get alcohol then they will use other substances with alcohol as well. A street drinker's main drug of choice is alcohol but they may also use benzodiazepines and other drugs and not really recognise that as a substance misuse problem.*

(Voluntary Services Manager 2)

Again, both Consultant Psychiatrists and the General Practitioner identified this as an area of concern.

*They're very important issues, with the increase in poly-substance misuse, for example, if individuals are often drinking and abusing cocaine there's a greater risk of overdose because the combination is worse than either alone i.e. cocaethylene.*

(Consultant Psychiatrist 1)

*It would be a huge problem and particularly if you've got additional mental health problems. Also, homeless street drinkers are at higher risk than the person that has a home and has more support. So it's always a potential and you're always trying to minimize that. Homeless street drinkers would be at significantly higher risk than the general population.*

(Consultant Psychiatrist 2)

The General Practitioner identified that people move between using different substances as well as using them together, making the issues more difficult to address.

*Significant proportions, around 10% have the dual addictions - alcohol and drugs. The dual addiction is a significant problem; often what happens is you get the person to stop using heroin and they then switch over to alcohol. Then you're working on the alcohol and they go back on the heroin. So they're switching from one addiction to the other and then there are the other people who are doing both.*  
(General Practitioner)

The General Practitioner went on to outline the main drugs that were found to play a significant part in recent overdoses within this cohort.

*It's mostly benzodiazepine, alcohol, methadone or heroin. A recent report from the coroner's office stated that methadone and benzodiazepine are often found in overdose with alcohol. My recent experience is that it's methadone: I've dealt with two overdose deaths recently and both of them included alcohol and methadone.*  
(General Practitioner)

This is a significant finding of this research as poly-substance use and the risk of overdose is not commonly associated with homeless street drinkers.

#### NON-COMPLIANCE WITH HOMELESS SERVICES AND MEDICAL SERVICES

The homeless street drinking cohort's unwillingness to comply with services was highlighted as a significant issue. This is not surprising due to the effects of alcohol on an individual's behaviour. However, non-compliance with services is a significant barrier to sustained and prolonged service delivery i.e. non-compliance often leads to a service being withdrawn even for the most tolerant of services.

*In terms of their lifestyles, the way homeless street drinkers live their lives doesn't necessarily suit how services are geared. Getting people to engage with other services is difficult because of their chaotic lifestyle.*  
(Voluntary Services Manager 2)

Voluntary Services Manager 2 identifies a problem within many services, she particularly suggests that for the most part services are not geared to how homeless street drinkers live

their lives and that these services often have unrealistic expectations of homeless street drinkers.

Voluntary Services Manager 2 went onto explain that due to the nature of this cohort compliance with medical regimes is difficult to abide by.

*One of the major issues is people being medically non-compliant. This has been the biggest problem for us and the pressure that this puts on staff that are not medically qualified to work with service users.*

(Voluntary Services Manager 2)

Voluntary Services Manager 2 described a common scenario of a service user leaving the Aungier St Project - wet hostel to be admitted to hospital, them being unable to cope with the hospital regime and self discharging from hospital. This has left the Depaul Trust Ireland in a dilemma does the organisation allow the individual that needs hospital care back into the Aungier St Project - wet hostel where the care is not available or do they refuse to take the individual back, knowing that the person will probably sleep rough.

The General Practitioner concurred on this issue, emphasising the very difficult combination of needs that this cohort present with and detailing the level of non-compliance.

*They're presenting with combined chronic medical, addiction, social problems and management difficulties; for example, a lot of the medical problems require treatment and medication yet they don't comply with them, there is a very low compliance rate. Non-compliance rates in the homeless population are in general 40%, that's taken across the whole homeless population, with people who are homeless street drinkers it is probably even higher.*

(General Practitioner)

THE EFFECTIVENESS OF CURRENT SERVICE PROVISION, IN DUBLIN CITY CENTRE, TO HOMELESS STREET DRINKERS EXPERIENCING CO-MORBIDITY.

An important issue presented here deals with the question of how successfully the complex issue of co-morbidity within this cohort is currently being dealt with by the range of human services involved. Unanimously, all respondents stated that there were deficiencies in the service delivery to homeless street drinkers experiencing co-morbidity. To this end, respondents generally felt:

*There is a big gap.*  
(Service User)

*It is very ineffective.*  
(General Practitioner)

*It's completely ineffective.*  
(Policy Maker 1)

*Co-morbidity is an issue that people have shied away from.*  
(Policy Maker 2)

*The psychiatric services are not flexible enough.*  
(Voluntary Services Manager 1)

*Ineffective, the psychiatric services in Dublin City Centre are unacceptable in relation to co-morbidity.*  
(Voluntary Services Manager 2)

*We need to make a decision in relation to how addiction and psychiatric services are going to deal with co-morbidity at the moment we're not really following any particular model.*  
(Consultant Psychiatrist 1)

*I think the current service delivery is hugely lacking and failing the homeless street drinker.*  
(Consultant Psychiatrist 2)



The first area of concern raised was the issue of sectorisation of services i.e. psychiatric services are divided by geographical areas and service delivery is therefore based upon where you live. By their very nature people who are homeless are without an address and at best transient between temporary accommodation. This has led to homeless people who are experiencing mental health difficulties receiving limited or no psychiatric services. This has impacted on both psychiatric referral and assessment.

*One of the problems is that if you look back to the catchment area strategy and if you read at the time it was being introduced, it was really to stop people leaving mental institutions from being lost, it really was intended to hold on to homeless people and its just interesting how peoples' behaviour then distort that and that was allowed to happen. The people who are administering or delivering services hide behind it and use it for some other reason.*

(Policy Maker 1)

*Psychiatrists will not want to see someone who is not in their area. They have bought into the whole rationale and it's a pity because it's a let down of their ethical duty. A lot of GPs on the ground avoid trying to do psychiatric admissions because they don't want to get caught up in this mayhem.*

(General Practitioner)

*Mental health services are focused on an address so if you're a homeless street drinker your falling through that gap in the system.*

(Consultant Psychiatrist 2)

According to this research, sectorisation of the psychiatric services, although intended to address the needs of this cohort, has failed this group.

Secondly, the issue of who had responsibility for co-morbidity was raised i.e. was it the mental health services or the addiction services. Both Consultant Psychiatrists were able to elaborate on this issue.

*If you have mental health problems plus an alcohol issue you are between services. Some of the primary mental health services will do their best to take them on, as will some of the addiction services. However, it's not their remit nor do they feel it's their responsibility to look after the homeless street drinker if they've got the two issues going on*  
(Consultant Psychiatrist 2)

*When individuals do require admission into a psychiatric hospital, certain psychiatric hospitals are less than accommodating for these individuals. Psychiatrically assessing somebody who has a drug or alcohol issue is not rocket science. However, there is also a certain element within psychiatry that would not be comfortable dealing with or may not see themselves as having a role in providing a service to substance users. They may not see substance users as falling within mental health and it can be used as a means whereby individuals don't receive care. This is where the serial model falls down considerably because the psychiatric service will say we can't deal with anybody until their addiction problem is dealt with. Some addiction services will say we can't deal with you until your psychiatric problem is dealt with. Unless the two are working together you're never going to have an appropriate service for an individual with a co-morbid disorder.*  
(Consultant Psychiatrist 1)

Significantly, Consultant Psychiatrist 1 went on to describe how they were able to work closely with a particular hospital as they had good relationships with doctors at the hospital, depicting a system of 'not what you know but who you know' approach to psychiatric service delivery to homeless street drinkers in Dublin City Centre.

There have been no new specific initiatives to address the issue of co-morbidity within this cohort. It was also considered that any related initiatives are not innovative enough as they work within the same restrictive practices of the wider Health Service Executive.

*There hasn't been a specific service response to co-morbidity although services like the ACCES team would work with people who have a mental health diagnosis and alcohol related issues.*  
(Policy Maker 2)

*Even where there have been teams set up to deal with homelessness and mental health they still very much have a mental health type brief. If they do decide to work with dual diagnosis their hands are tied, as well.*

(Voluntary Services Manager 2)

This system failure and lack of innovation leads to very real human tragedy as highlighted by the General Practitioner.

*We sent a drug user, who had an alcohol problem and who was distinctly suicidal, up to hospital in a taxi and the psychiatrist said alcohol was her problem. As alcohol or drugs had been the problem they didn't take the suicide threat seriously, that person committed suicide two days later.*

(General Practitioner)

It is clear from this research that sectorisation of the psychiatric services, the lack of clarity on responsibility for co-morbidly diagnosed homeless people and the consequential lack of accountability has caused inter-professional tensions between the psychiatric services and other related services i.e. the primary care services, addiction services and homeless services. This amounts to unproductive squabbling between disciplines on a daily basis.

PROBLEMS WHICH ARISE IN ARRANGING TO HAVE HOMELESS PEOPLE PSYCHIATRICALY ASSESSED WHEN THEY ARE STILL ACTIVELY MISUSING ALCOHOL AND / OR OTHER DRUGS

The initial area highlighted by respondents, when considering the difficulties in arranging to have homeless people psychiatrically assessed when still actively using alcohol or drugs, was the confusion as to which issue to address first, should the addiction be addressed first or the psychiatric issue?

*Mental health services will look and say well his problem is addiction and unless the addiction is dealt with we can't deal with the mental health problem. There's a dysfunction in the services that seems not to be able to look at the person as an entity as opposed to as an 'ism', a problem or a diagnosis.*

(Policy Maker 1)

*The main problem is psychiatric staff will tell you that the presenting issue isn't mental health it's drugs or alcohol and until people address their substance misuse they can't assess their mental health properly.*

(Voluntary Services Manager 2)

*For psychiatrists who aren't used to dealing with the issue, it's teasing out whether the primary problem is the psychiatric illness or a substance misuse problem. Sometimes it's the chicken/egg scenario. What we tend to do is look at both problems. Obviously, if someone has a psychiatric diagnosis which is depression and they're drinking then any intervention that you're providing isn't going to be as effective unless you treat both.*

(Consultant Psychiatrist 1)

Secondly, respondents identified that current assessment techniques within the wider psychiatric services and the specialised psychiatric services do not allow for the safe assessment of individuals under the influence of substances.

*We can't practically do an assessment when someone is intoxicated. When they're drinking first thing in the morning, an accurate psychiatric assessment can't be done because they present so differently when they're sober. They cannot be adequately assessed not safely. Particularly not for problems like suicide they can't really be assessed properly for that. You're doing a lot of guesswork which isn't good care.*

(Consultant Psychiatrist 2)

*If you can get a mental health professional out to assess a person, which is difficult in itself, you will find that if the person to be assessed is under the influence when they turn up then they will say they can't assess them.*

(Voluntary Services Manager 2)

The Service User offered his experience and frustrations at this gap in the system.

*I often went up and I'd have a drink on me, just to get the courage to go up and see a psychiatrist, because I knew there were other issues there. I'd be turned away, so the opportunity was lost.*

(Service User)

Even if conceding that safe psychiatric assessment of those under the influence of alcohol may be difficult, current psychiatric assessment offered to this cohort was considered unacceptable.

The final area of concern when attempting to arrange to have homeless people psychiatrically assessed when they are still actively using substances, was the poor attitude these individuals faced from professional staff. The General Practitioner and Consultant Psychiatrist 2 highlighted that attitudes by professionals towards those experiencing co-morbidity hindered progress.

*There's a distinct sense that a lot of the mainstream psychiatric services don't want to deal with them.*

(General Practitioner)

*It's very difficult; it's hard to get the person to the traditional services. Take for example traditional outpatient appointments, because the services are so busy they might have ten people waiting for an appointment, there isn't a keenness to accept a drunken potentially hyper-verbal person in the waiting room. People don't want him or her around.*

(Consultant Psychiatrist 2)

#### NON-COMPLIANCE WITH PSYCHIATRIC SERVICES

As with homeless and medical services the issue of non-compliance was acknowledged as a significant issue.

*Compliance in the general population is a problem; it may be heightened in relation to the group that we're specifically talking about because of the chaotic nature of their circumstances.*

(Consultant Psychiatrist 1)

*If you are compliant, taking your medication, keeping appointments and doing all those things, then you're probably ok within the mental health service. If you are not compliant then you are not ok within the mental health services. By definition those people you are describing are not compliant, they won't take their medication, they will be challenging, they will be difficult and so they're not kept within the system and that's a major problem.*

(Policy Maker 1)

The Service User interviewed has suffered with depression since a young adult and he shared a lot of his personal experience of psychiatric institutions from circa 1970s onwards. From the Service User's perspective these were not positive experiences and they highlighted periods and episodes where he would not comply with psychiatric regimes.

*When St Brendan's took me in I'd argue with them because they weren't treating the alcohol, they weren't treating the depression, I don't know what they were treating because they were giving me all these heavy psychotic drugs. But I kicked up over it and ended up in the lock-up ward and because I ran out once or twice from the open ward, they said well this is the way we're going to treat you now. It was on my file, one of the doctors showed me "straight to number 8", that's the lock-up ward, any time I came in the assessment unit they were to send me straight there. I didn't get the chance to get rehabilitated, I was in ward number 8 and there were people there with huge mental illnesses.*

(Service User)

The Service User explained how he was requesting access to his files under the Freedom of Information act and was seeking further knowledge regarding the rationale behind his treatment. However, the following extract highlights a recent positive experience for the Service User.

*In October 2005 the consultant at St Vincent's in Elm Mount said we can help you with the depression. So, once a month I go and see my consultant and sit down and chat about what is going on for that month, at the beginning it was every week and then every two weeks and now it's every month. I sit down and talk to her about what is going on within me, my anxiety problems, and we work through it. We discuss if my medication needs to be upped or reduced, and so far it hasn't had to happen, it's stable. Then she'd talk to me about the alcohol. I've never experienced any of this before with psychiatrists. There was none of that. Now there is, they are listening.*

(Service User)

Consultant Psychiatrist 1 concurred with the Service User, explaining that the correct treatment of a depressive disorder has a marked impact upon compliance and went onto to outline other interventions that impact on compliance with psychiatric regimes.

*Other issues that have been identified as improving compliance in this population would be appropriate treatment of the depressive disorder. If you treat the*

*depression appropriately then their compliance with a range of medication is significantly improved, there are other practical measures like pill boxes, given out to individuals which aid compliance. Some services have looked at alarms and reminders, like getting hostel staff involved in improving compliance for our population. Compliance is an under recognised problem but there are many ways that you can improve compliance in your population even among homeless street drinkers.*

(Consultant Psychiatrist 1)

## EFFECTIVENESS OF CURRENT SERVICE DELIVERY TO THE HOMELESS STREET DRINKING POPULATION OF DUBLIN CITY CENTRE

Overall it was felt services to homeless street drinkers in Dublin City Centre had improved since 1996, when the Homeless Initiative was established. That particularly over the last six years, improvements had been made with regards to the development of specialist services i.e. a wet house, a residential detox unit and dedicated specialist outreach teams. Both policy makers responsible for this period of time and development for these services concurred on this issue.

*The answer is we are doing better than before. For example, if you look back ten years, there wasn't a wet shelter; there was nowhere where you could drink on site. Now people can drink in places so that is an improvement.*

(Policy Maker 1)

*For me the move on has been that people who were street drinkers were dying on the streets, they weren't getting access to services. That has changed; there is now access to a range of services both within accommodation and treatment.*

(Policy Maker 2)

When respondents were asked about the effectiveness of services they focused on the following services: Depaul Trust Ireland's Aungier St Project - wet hostel, the Dublin Simon Community's Addiction Services, the Assertive Community Outreach Evaluation Services (ACCES) Team (the mental health service that works with the mentally ill and

homeless) and finally the South Western Area Health Service Executives Homeless Multi-disciplinary Outreach Team.

#### AUNGIER ST PROJECT - WET HOSTEL

Respondents considered the Aungier St Project an effective but limited response. It was acknowledged that the project had been effective in reducing the number of deaths on the streets of Dublin City Centre and that people now lived, and sometimes died, with dignity. Aungier St Project was credited with challenging people's attitudes towards homeless street drinkers and helped to influence other services to change their approaches to homeless street drinkers, an example of this would be the Dublin Simon Community's Harcourt Street Hostels 'wet room'.

*People's perception has changed as well and I think Aungier Street has done a lot of that. . . . Leading on from Aungier Street wet hostel people are saying, "Oh wait people don't remain chaotic in their lifestyles forever; some people with support will find that they can move away from living on the streets!"*  
(Policy Maker 2)

Although attitudes and perceptions had improved, it was also acknowledged that there was still work to be done across services to ensure that all appropriate services worked with homeless street drinkers. In an attempt to avoid creating a safety net within a safety net scenario, where only specialist services worked with this cohort of people.

*There is still work to be done regarding some of the services perception of who they can work with.*  
(Policy Maker 2)

It was stated that the physical building at 79 Aungier St did not lend itself to the purpose of the project. Particularly, due to the limited internal and external communal spaces harm reduction measures were often not possible.



*In terms of the vision of a wet hostel in 'Under Dublin's Neon' Aungier Street probably achieved about 70% of what was looked for and a lot of its failings is around the confines of the building.*

(Policy Maker 2)

Consultant Psychiatrist 2 concurred on this issue, stating that the effectiveness of the service provided was questionable due to the physical space issue and she too raised concerns regarding the opportunities available to carry out harm reduction interventions.

*The wet hostel in Aungier Street as it is, it has the potential to provide a very good service. However, in its current residence it is really unfortunate because it's just not safe for people. There isn't enough space for people as a consequence there isn't enough harm reduction going on there.*

(Consultant Psychiatrist 2)

The Service User was able to give a picture of the drinking behaviour in the project.

*In Aungier Street there's crates coming in and bottles, and bottles, and it's grand because it's what they're used to.*

(Service User)

This lack of harm reduction intervention coupled with this level of drinking was considered cause for concern.

Move on options from Aungier St project were not available for those continuing to drink which had caused a bottleneck effect for the project. This was not the intention as Aungier St project was established as emergency accommodation.

*Aungier Street was supposed to be short term support to meet people's immediate needs and then there would be follow through; there hasn't been that follow through.*

(Policy Maker 2)

#### THE DUBLIN SIMON COMMUNITY'S ADDICTION SERVICES

The Dublin Simon Community's Addiction Services were viewed as effective. They were credited with offering a realistic option for those street drinkers wishing to stop drinking. It was acknowledged that the residential detox worked well due to its flexible admissions policy and the fact that a person could arrive under the influence of alcohol. The rehab and aftercare filled a very important gap in services for those people often isolated from family support.

*Prior to the Dublin Simon Addiction Services model, people would often not make it through the follow on from the detox because their family support and the community support weren't in place.*

(Policy Maker 2)

#### THE ASSERTIVE COMMUNITY OUTREACH EVALUATION SERVICES TEAM

There were mixed responses to the effectiveness of the Assertive Community Outreach Evaluation Team (ACCES Team). The fact that the team still worked within the geographically sectorised system of the Health Service Executive and could only work with individuals on the south side of Dublin City, within a limited geographical area, was not considered helpful as many of the people with these difficulties were on the north side of the city. It was also stated that the team had some way to go to integrate itself with mainstream services. This would help to avoid a division of this specialist service from mainstream services.

*The ACCES Team is still very new and it has got a bit of work to do towards integrating its service with mainstream services.*

(Policy Maker 2)

## THE HOMELESS MULTI-DISCIPLINARY OUTREACH TEAM.

Although considered a welcome development, it was evident that the lack of resources available to the Homeless Multi-disciplinary Outreach Team was hindering their work. Particularly the Health Service Executives embargo on recruitment had left the team without key personnel and the lack of access to beds had meant that, referral wise, the team had little more to offer than what was already available in the system.

*The difficulty is when they set up the team is that they didn't have access to beds. Public policy can only address these issues if it's got the resources to follow through.*  
(Voluntary Services Manager 2)

Finally, it was argued that if, as a result of these overall improvements, people are now housed and in from the streets; that it is therefore, no longer a homelessness issue. That the immediate need for shelter has been met and that now we have a better understanding of the needs of this group of people.

*Homelessness isn't the issue anymore, people have shelter and they really need to be taken out of the homeless category, they're then people with other issues. If they cannot be housed and housing is not the solution then homelessness is not the problem. So if you have people in homeless services who are there because they can't be housed somewhere else then their problems are more than just homelessness.*  
(Policy Maker 1)

Policy Maker 1 went on to outline the key issues affecting homeless street drinkers as mental health, addiction or behaviour issues. Policy Maker 1 argued that these are the issues and by successfully providing services we have opened 'a can of worms'. She argued that these issues are and should be outside the remit of the homeless sector. That this is challenging for those agencies that were quite happy that homeless street drinkers were previously slipping through gaps in the system, with their issues never really being

addressed. Now these people are being held onto long enough to work with, the cracks in the system are easier to identify and that means there is a wider policy impact.

#### THE EFFECTIVENESS OF CROSSCUTTING POLICY INITIATIVES IN MEETING THE NEEDS OF HOMELESS STREET DRINKERS.

This research has found that the needs of homeless street drinkers have been somewhat met through cross cutting policy initiatives. There was a mixed response from respondents with regard to effectiveness of cross cutting policy measures.

It was considered that cross cutting policy initiatives like the Strategic Management Initiative (SMI) had impacted very little. The issue of too much government policy and not enough implementation of government policy meant that respondents were frustrated with the amount of rhetoric. Resources not being made available to crosscutting policy statements/strategies also frustrated respondents.

*While there is a lot of policy, there is not a lot of implementation of policy.*  
(Policy Maker 1)

A reason given for this lack of implementation was the system being defective, specifically that the Cross Departmental Teams established under SMI were seen as ineffective.

*If you look at the cross departmental teams they don't work in the way they are intended to work which is to join up on issues between the different areas of responsibility. The Department of Health, the Department of Justice, the Department of the Environment, etc. they all go to the meetings but they continue to remain in their camps and they don't work as a team.*  
(Policy Maker 1)

This continuing departmentalised approach to policy making in the guise of a crosscutting systematic approach is not seen as helpful. Policy Maker 1 went on to paint a bleak picture of the Cross Departmental Groups that they had been involved with.

*Joint working doesn't happen at a central government level, not at all. I haven't seen joint working between departments happen on any issue that I have been involved with.*

(Policy Maker 1)

At a local level, in Dublin, a better picture of cross cutting policy making is presented. The Homeless Agency is on the whole considered to have been a success in this regard.

*In the Homeless Agency there is a fairly sophisticated level of joint working and it took a number of years to get it to achieve this. People in the Homeless Agency are now able to put aside this notion that "I'm the Health Service Executive" and "I'm the Dublin City Council" and work together as a team to solve problems.*

(Policy Maker 1)

Consequently members of the Homeless Agency are often acting outside of the corporate position of their own organisation or have to fight within their organisation on issues that they are attempting to address with partner organisations within the Homeless Agency. This equates to the Homeless Agency being dependent upon strong personalities that champion different causes. As the General Practitioner outlines from his perspective it is the individual championing a cause that has made real differences.

*With regard to cross cutting policy initiatives affecting homeless street drinkers, a number of people have impacted and made differences.*

(General Practitioner)

From a primary health care perspective it was found that there is no one driver who is coordinating all these strands into one strategy to make sense of what is happening on the ground and that there is a real sense of opportunism rather than planning.

*In terms of 'Primary Care - health policy' for this group there's no one group or one person that's got the overall vision that drives the changes.*

(General Practitioner)

It was anticipated that the Health Service Executives National Director of Social Inclusion would start fulfilling this role. The General Practitioner called on the Health Service

Executive to address this issue in a strategic manner by placing social exclusion at the top of the Health Service Executives own mission statement.

*It is the HSE's responsibility, in its own mission statement it says that it wants to provide for the health care of the population. It particularly makes reference to socially excluded people, this is at the end of its mission statement. If the HSE was to aim to provide the best services to people who are the most excluded. Everybody would benefit, because with those services in place everybody would gain. So we feel that they should become the primary target. There is still a sense that socially excluded people are the 'add on'. The HSE should be responsible for all the healthcare needs of homeless people and services that are provided taking into account all those with complex needs.*

(General Practitioner)

The issue of formulation of policy, and again non-implementation, were raised as significant issues. Two recent national policies, that would have implications for policy relating to homeless street drinkers, were highlighted as particularly concerning. Firstly, the 'Strategic Task Force on Alcohol's report, 2004' is a good example of compromised policy formulation and implementation. This national policy document prepared for the government regarding national alcohol policy should have an impact on the homeless street drinking population, for example, the document covers such areas as the availability of alcohol, preventative strategies and cost. It is clear from the formulation and implementation of this policy that national alcohol policy is strongly influenced by the lobbying of the alcoholic beverage industry.

*There have been positions taken on a number of policy papers produced which have not been of benefit to individuals with substance misuse problems. The Strategic Task Force on Alcohol's report, 2004, is one such policy document which contained good recommendations. These recommendations have not been followed through on due to a lack of commitment from the government and it is clearly because of the influence of the drinks industry.*

(Consultant Psychiatrist 1)

The second policy highlighted as a concern was ‘A Vision for Change – Report of the Expert Group on Mental Health Policy’ February 2006. This document caused concern for the Clinical Psychiatrists interviewed as the document clearly states that the major responsibility for care of people with addiction problems lies outside of the mental health system and lies with the Primary Health Care system.

*In terms of developing clinical based services for psychiatric difficulties and problems what ‘A Vision for Change’ has done to drugs and alcohol is a scandal. They have removed addiction from mental health, making Ireland the only society in the world where mental health no longer has the remit for addiction. If you look at the international classification of diseases or the diagnostic manual from the United States which are the gold standards in relation to mental health both have very strong chapters in relation to addictive problems addictive disorders for both drugs and alcohol. This document seeks to move addiction to primary care, it barely mentions the problem of alcohol and it focuses on addiction psychiatry solely with those psychotic, violent, aggressive substance misusers who the general psychiatric service units do not want to have on their units.*

(Consultant Psychiatrist 1)

The General Practitioner concurred with this ‘washing their hands’ of the issue by the psychiatric field.

*Psychiatry let certain diseases in then throws them out when it can’t really do much. Alcohol was a psychiatric condition but psychiatrists I don’t think liked dealing with alcohol because they find that they can do very little. So a lot of psychiatrists are pushing alcohol over to other services; away from them.*

(General Practitioner)

In relation to this issue, Consultant Psychiatrist 1 pointed out that he had been a member of a subcommittee for ‘A Vision for Change’. Consultant Psychiatrist 1 stated clearly that the recommendations from the subcommittee made to the expert group were ignored. Broadly, the recommendation was to develop an appropriate drug and alcohol service under the umbrella of mental health.

*This document produced by the expert group is not based on any international evidence, it is not based on any model of best practice and it is not based on any submissions that were made to the expert group. They have been completely ignored the recommendations that the subcommittee came up with and I think it reflects personal bias of people on the expert group as opposed to anything else.*  
(Consultant Psychiatrist 1)

Taking all of the above into account this does not give a picture of evidence based policy making in Ireland. Consultant Psychiatrist 1 went on to describe two decades of neglect with regard to alcohol services, which reinforced his beliefs with regards to current policy making on this subject.

*If you look at our response to the problem of alcohol dependency over the last twenty years since 'Planning For The Future'. The Department of Health have to take culpability, in that, over that twenty years alcohol services have been eroded, starved of funds, pushed away from psychiatric services, pushed away from mental health services and over that twenty years we have become the biggest drinkers in Europe and its directly because of government policy around alcohol. 'A Vision for Change' has simply re-enforced that and it goes hand-in-hand with the government's response to the 'Strategic Task Force on Alcohol' recommendations, it's appalling.*  
(Consultant Psychiatrist 1)

Consistently across the interviewees there was optimism and pessimism for policy making in Ireland for this cohort. There was a stronger sense of confidence in local policy making as opposed to national policy making. Whether it was opportunistic or consultative policy making respondents felt they had more opportunity to impact locally. This is unfortunate, as without leadership on a macro level there will be a patchwork policy response to the homeless street drinking issue locally across Dublin and Ireland.



## FUTURE INITIATIVES THAT WILL IMPACT POSITIVELY ON THE LIVES OF THOSE PEOPLE LIVING A STREET DRINKING LIFESTYLE IN DUBLIN CITY CENTRE

When asked for a single policy initiative that would impact upon this cohort, respondents answered with various priorities. Few were able to name one response but instead named a number of areas that would need to be addressed for positive progress to be made. Areas that were addressed included: vision and leadership, responsibility and accountability, a primary health care strategy, co-ordination of services in relation to co-morbidity, a dedicated day/night service, innovative long term housing solutions, case management, compliance and service user involvement.

### VISION AND LEADERSHIP

As the General Practitioner highlighted earlier, it would appear there is no vision for the Primary Health Care for this cohort. Other respondents also felt that an overall vision is essential for the future, one that brings together all the various services that impact on this group. Significantly, above and beyond a co-ordinated vision that embraces joint working, two areas were highlighted. These were continuous monitoring & evaluation and a preventative strategy.

*Sometimes after services develop people think, "Oh that's that sorted". We need to be constantly assessing what are the needs of people presenting. People's experiences are changing all the time, so we need to be responsive to that.*  
(Policy Maker 2)

Policy Maker 2 went on to explain how evaluations of homeless services to this cohort are currently taking place and that a reconfiguration of services will be necessary.

*We have begun to do service evaluations; part of this is to see what kind of reconfiguration may be needed.*  
(Policy Maker 2)

Policy Maker 1 stated that there are established progression routes into a homeless street drinking lifestyle and with this in mind a preventative strategy should be established in an attempt to stop people going down these paths. Policy Maker 1 outlined a recent scenario that illustrated her point.

*When researcher 'O' was doing work in the wet hostel, he knew nearly everybody there because they had been in Galway Simon, Cork Simon, etc. The first four or five that he met had all been brought up in Letterfrack. There's a pattern, there's such a clear sense of cause and effect, between the circumstances that people have early on in their life and where they end up. Putting strategies in place that helps prevent more of them coming through in the future is an important thing to do.*  
(Policy Maker 1)

#### RESPONSIBILITY AND ACCOUNTABILITY

Ironically, considering the difficulties that sectorisation of psychiatric services has caused this cohort, it was felt that local responsibility for homeless street drinkers was necessary. It was accepted that protocols for movement between geographical areas and clear monitoring and measuring of service provision to ensure accountability would be necessary. The rationale for this is that within the current situation people experiencing these difficulties are moving between areas, often moved by the Gardai or attempting to access hostels and accommodation in different areas. Nobody locally is taking responsibility which adds to the revolving door scenario experienced by this group.

*Locally focused services, integrated around a particular geographic area and within that people on the street should be the responsibility of whatever team is responsible for that area. Similar to what Dublin City Council is doing with Local Homeless Forums. They need to be monitored, measured and somebody needs to be responsible for what happens in those areas for homeless street drinkers; a sensitive, practical, balanced approach.*  
(Policy Maker 1)

## A PRIMARY HEALTH CARE STRATEGY

The General Practitioner outlined a proposal that his service had made to the Health Service Executive which had been received positively. This proposed, through the employment of a Medical Director, the co-ordination of the primary health care professionals currently working in Dublin City Centre and the development of a GP led care facility. This facility would be designed to address the health care needs of homeless people who fall between the Hostel and Hospital gap, as outlined previously by Voluntary Services Manager 2.

*There are a number of services such as GP, nurse, chiropody, counselling, dentistry, occupational therapy, etc. They're all providing these services but they're all in different voluntary organisations. All these services don't know about each other, the idea of bringing all those services together is to maximise the potential and also to create an entity that will drive change. Secondly, create an intermediate care facility within the context of a confluent system of health care provision. This needs a driver, a Medical Director, that person needs to be in the service driving the need for health care provision i.e. the Health Service Executive. This would also ensure the accommodation sector makes the necessary provision.*  
(General Practitioner)

## CO-ORDINATION OF SERVICES THAT ADDRESS CO-MORBIDITY

With regards to co-ordination of services in relation to co-morbidity this research found that respondents were eager to see closer joint-working between addiction services, psychiatric services, primary care services and housing services. This included dedicated teams of mental health professionals and addiction professionals, but also existing statutory and voluntary based specialist services working together.

*The mental health and addiction services need to come together and have proper multi-disciplinary teams and outreach teams for homeless street drinkers to be able to treat them with the care they deserve.*  
(Consultant Psychiatrist 2)

Consultant Psychiatrist 1 described his preference for a parallel model where individuals with serious co-morbid problems could be effectively managed between the addiction services and the psychiatric services. This would require improved liaison, better communication and greater supports being put in place. Consultant Psychiatrist 1 outlined his preference for Clinical nurse specialists to facilitate this development.

*Clinical nurse specialists with a psychiatric background working between the two services would be an effective measure. A parallel process in terms of psychiatry and addiction will have tremendous benefits.*

(Consultant Psychiatrist 1)

Consultant Psychiatrist 1 further elaborated on the rationale for the parallel service to address the effectiveness of interventions regarding co-morbidity.

*Co-morbid issues must be treated together as either intervention alone isn't going to be effective and that's why the whole issue around the parallel services is so important.*

(Consultant Psychiatrist 1)

The Service User gave an example of his recent experience which would strengthen the argument for increased joint working for the co-morbidly diagnosed.

*I'm getting great help where I am now; they referred me up to the (psychiatric) day centre. It's a good service and they're also linked in with my care worker here. So if I don't attend the clinics, they would be in touch with her. To see were you ok and that's a good service, they're linking in with me.*

(Service User)

The Service User's experience highlights the benefit of joint working in addressing the issue of ensuring that people do not fall between gaps in services due to poor communication.

Building on this issue of joint working respondents were keen to see a shift away from addressing issues with a singular mindset. Ensuring all new services would be developed

to work with more than one issue i.e. alcohol, drugs, mental ill health, behavioural issues; whatever presented.

*We must embrace harm reduction and take a more holistic approach to dealing with an individual and realise that you can't keep de-compartmentalising into drugs, alcohol or mental health.*

(Voluntary Services Manager 2)

It was also desirable to see a dedicated service for homeless street drinkers experiencing co-morbidity in Dublin City Centre:

*A lot can be dealt with as an out patient, you don't necessarily need to build lots of wards and bring people in, but there are certain cohorts of homeless street drinkers who do need an admission into a safe facility. So that not alone can they get an alcohol detox but many of the psychiatric and medical problems can be addressed. Individuals wouldn't have to be admitted for very long.*

(Consultant Psychiatrist 1)

It was pointed out that this would need resources and professional manpower to deliver an appropriate service to this population. That we can limp along as we are with a few people providing a patchwork of interventions to the homeless street drinking cohort or we can see it as a significant problem and put in money to develop teams, resources, day programmes and a small provision for inpatient facilities for those individuals in most dire need.

Consultant Psychiatrist 1 argued that to save money we must spend money.

*It costs money, but if you look at the high cost to society which this cohort of patients can cause both in terms of health care and forensic problems. Then that injection is money well spent and there is a return on your investment in terms of savings.*

(Consultant Psychiatrist 1)

## A DEDICATED DAY/NIGHT SERVICE

The Service User called for a dedicated service, describing a low threshold harm reduction day/night service in Dublin City Centre. A wet service designed for homeless street drinkers that would have the ability to tolerate difficult behaviour and address the issues that cause the behaviour i.e. mental health, behavioural issues, drug and alcohol use.

*There should be a place set up that they can say this place is specifically geared towards your specific needs. For people who have a dual psychiatric problem, a place that's safe to go into. It should be fully staffed so they could go in and maybe have their drink in there. If they're taking drugs, there should be a space set up for drug users, where they can have their drugs, consumption rooms. If they knew they could walk into a place where they could shoot up and dispose of needles safely, they would and they could be kept an eye on.*

(Service User)

## INNOVATIVE LONG TERM HOUSING SOLUTIONS

One respondent went as far to say we should get rid of all emergency accommodation as we are merely warehousing people. Arguing that this would enable us to focus on providing long-term housing and support to this cohort.

*Get rid of the whole concept of emergency shelters there should be no temporary accommodation. You are just warehousing people because you need to get people in from the streets.*

(Voluntary Services Manager 1)

Building on this notion, new innovative long-term housing options for this group were highlighted as essential. Extending the notion of housing this group in emergency harm reduction projects, like the Aungier St Project – wet hostel, to long term housing with support.

*Build upon the harm reduction model, transfer what was an emergency harm reduction model to longer term support.*

(Policy Maker 2)

To avoid institutionalisation these projects should not be large scale but more intimate and homely, to provide the best opportunity for the individual to settle.

*Move-on housing not on a large institutionalised scale but on a small scale with small units working effectively with people.*  
(Voluntary Services Manager 2)

#### CARE AND CASE MANAGEMENT

A care and case management approach was highlighted as essential in the coordination of services to ensure a successful joined up approach between the key stakeholders addiction services psychiatric services and accommodation services.

*Case Management - working within a multi-disciplinary approach, dealing with more than just a piece of the person. Case Management - that will change the way that the various disciplines work.*  
(Policy Maker 1)

#### COMPLIANCE

As Consultant Psychiatrist 1 outlined earlier, there are innovative ways to improve compliance. Whether with medical services, addiction services or homeless services, it was proposed that the issue of compliance be considered as a matter of priority.

The General Practitioner called on the Health Service Executive to lead on the issue of compliance. They cited the example of the hostel providers' current dilemma with regards to 'monitoring' as opposed to 'dispensing' of medication to hostel residents that need this support.

*There is a difficulty with a number of our satellite services, particularly in hostels, with staff dispensing medications. There is no overall policy from the HSE for example in any of the hostels there's no policy as to whether the staff can dispense medication. The HSE should train staff and have a protocol which crosses all hostels. They should indemnify the staff because for the staff the big difficulty is that they feel that if they give the wrong medication they're not indemnified. The HSE should do this because if service users are not taking their medication then of course they're going to become unwell. What's the point of putting money into these GP services if people don't take their medication? 40% to 60% aren't taking the medication and that's a huge failure rate in your service.*  
(General Practitioner)

By developing an overarching policy in the dispensing of medication for all service providers and indemnifying staff involved in this work. The implication is that the compliance rate and consequently the health of the homeless population will improve.

#### SERVICE USER INVOLVEMENT

Finally, one respondent called for more service user involvement. Stating that the opinions of those people using the services need to be sought and opportunities for expressing their needs should be more readily available to homeless street drinkers.

*Provide resources for street drinkers; have more forums where they are able to express themselves and tell us what they need, instead of our wonderful opinions, which aren't so wonderful at all!*  
(Consultant Psychiatrist 2)

#### SUMMARY OF FINDINGS

From these responses, we can summarise that this cohort is changing, that poly-substance use and the risk of overdose are significant issues, non-compliance across a range of services further compounds the difficulties faced by this group, that co-morbidity is common place amongst this cohort and that general psychiatric services are unwilling or



unable to cope with the co-morbidly diagnosed. Responses that have worked well for this cohort in Dublin City Centre have been arranged through local cross cutting policy initiatives and through joint working by service deliverers. The research findings are discussed and expanded upon in the next chapter.

## **CHAPTER FOUR: DISCUSSION AND CONCLUSION**

The aim of the research reported here was to explore the extent to which the various voluntary and statutory agencies concerned with homeless street drinkers in Dublin are succeeding in meeting the needs of this group. The research and policy literature, which was reviewed in detail in Chapter One, confirmed the complexity of the issues involved in this process. Even basic definitions of homelessness are contentious and it can no longer be assumed that people characterised as street drinkers are consumers only of alcohol, since they are likely to be using a range of licit or illicit substances. However, the literature also revealed that at a high policy level there is now a clear understanding of the importance of co-ordinating or integrating policy and service responses, and in Dublin this was being approached under the banner of the Strategic Management Initiative with its emphasis on 'cross-cutting' management of complex issues.

The findings of the qualitative, semi-structured interviews (with policy makers, service providers and one service user), which were presented in detail in Chapter Three, reveal mixed findings. There was agreement that the clients described here as homeless street drinkers are in flux, in the sense that some of their important or defining characteristics have recently changed. Currently, these people do not satisfy traditional definitions of 'homelessness' since they are more likely to be living in hostels or other temporary forms of accommodation than literally living rough or without shelter. Respondents also believed that younger people are now becoming involved in street-drinking lifestyles, and that not all of these young street drinkers are as immediately recognisable in terms of previous stereotypes of street drinkers. Furthermore, there was consensus that the subjects of this

research tend nowadays to be polydrug users rather than simply alcohol consumers: it was also agreed that this combination of alcohol and other drugs led to greater risk of overdose than would be associated with alcohol on its own.

It was clear from the views expressed by respondents that, in philosophical terms, service provision has now shifted to an unequivocal acceptance of harm reduction for homeless street drinkers. Despite the fact that traditional service responses were based on abstinence-only models of provision - and largely located within religious or temperance-type agencies (Butler S (2003), p.8) - there has now been a general acceptance of pragmatic strategies aimed at reducing alcohol-related harm rather than solely at bringing about abstinence. This change has been particularly reflected in the creation of a 'wet hostel', both in Dublin and in other Irish urban settings, and it was notable that respondents in this research commented only on the physical suitability of the Dublin wet hostel rather than becoming embroiled in moral argument as to its basic aims and objectives.

On the wider question of whether service responses have improved, the views expressed were not always consistent: on the one hand, considerable cynicism was expressed about the value of the 'joining-up' activities advocated by high-level management under the rubric of SMI, while on the other hand there was agreement that services had improved.

Areas of concern focussed on by respondents included the inability of this cohort to comply with a range of services. This was seen as a significant issue which necessitates that services be flexible and innovative in their approach and requires leadership from the Health Service Executive. Co-morbidity was also seen as a significant issue for this cohort

and psychiatric assessment was identified as a major block. Service delivery that embraces harm reduction and joint working between addiction, psychiatric and housing services was seen as essential in addressing these issues.

Some of the positive improvements highlighted by the research include the development of specialised services for homeless street drinkers in Dublin City Centre i.e. the wet hostel, the residential detox and specialist outreach teams. With respondents making recommendations for further specialised services that would work in partnership with existing services to address the often unique and challenging issues faced by homeless street drinkers.

This research has found that a rising tide does not leave all boats, that for those people who experience social, economic or health problems their lot in life may never improve. Society's response to these individuals requires policy makers and service deliverers to think laterally, in a joined up and cross cutting manner to ensure that we impact positively on the lives of this socially excluded group.

Is service delivery to homeless street drinkers in Dublin City Centre effective? The answer is a resounding - definitely maybe. In the final analysis, despite cynicism regarding cross cutting policy initiatives respondents do actually see progress in responding to the needs of this most complex and challenging group of service users.

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