**Tallaght
Homeless
Advice
Unit**

Heroin – the mental roof over your head

Links between homelessness and drug use

Community/Voluntary Sector
Research Grant Scheme

NACD

National Advisory
Committee on Drugs

Heroin – the mental roof over your head
Links between homelessness and drug use

Based on a report prepared by Marie Crawley and Mary Daly

for the

Tallaght Homeless Advice Unit

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Table of Contents

Foreword

I am delighted to be able to introduce these excellent reports from the Community & Voluntary Sector Research Grant scheme. The Terms of Reference of the National Advisory Committee on Drugs (NACD) commits to finding ways "to maximise the use of information available from the Community and Voluntary Sector". Thus a research grant scheme aimed directly at this sector was developed. Such was its centrality to the work of the NACD that its development and implementation was designated as a key role for the Research Officer.

After launching the grant scheme, the NACD received over 100 enquiries and received 35 applications from across the country. Following a review and short-listing of the applications, eleven groups were invited to participate in a training workshop and finally five grants were issued. Four organisations completed their research projects and this report is one of the four launched by the Minister of State with responsibility for the National Drugs Strategy in October 2004. Clearly the aims of the research grant scheme were achieved: to build capacity; to inform gaps in our knowledge and to contribute to the development of public policy.

The NACD's Research Officer, Ms Aileen O'Gorman developed the grant scheme and provided ongoing liaison and support to each group helping them to implement their research studies and bring them to publication. My colleagues and I wish to place on record our deep appreciation of the significant contribution she has made to this project. The commitment of all those involved from the community projects and their Research Advisory Groups must be acknowledged and their achievement in producing such valuable information to the NACD and their own communities is to be commended.

The NACD is in the process of commissioning an external review of this scheme and subject to a positive evaluation, hopes to be in a position to recommend continuation of this grant scheme in the future.

I would like to thank everyone involved, the staff of the NACD and finally, Ms Kate Ennals who provided editorial support in bringing the reports to publication stage.

Dr Des Corrigan
Chairperson
National Advisory Committee on Drugs

Preface – NACD Community/Voluntary Sector Research Grant Scheme

NACD

The National Advisory Committee on Drugs (NACD) was established in July 2000 to advise the Government in relation to problem drug use in Ireland, based on the analysis of research findings and information. The Committee, whose members are drawn from statutory, community, voluntary, academic and research organisations as well as relevant Government Departments, oversees the delivery of a comprehensive drugs research programme on the extent, nature, causes and effects of drug use in Ireland. The Committee reports to the Minister of State responsible for the National Drugs Strategy in the Department of Community, Rural and Gaeltacht Affairs.

Community/voluntary sector research grant scheme

In December 2001 the NACD launched a *Community/Voluntary Sector Research Grant Scheme* to generate innovative, community-based drugs research. In a nationwide advertising campaign, groups working in the community/voluntary sector that were interested in conducting research in the areas of prevalence, prevention, treatment/rehabilitation and the consequences of problem drug use, were invited to submit applications to the scheme.

Application process

The grant scheme was developed with monitoring and support mechanisms built in at all stages from initial application to the conclusion of the research studies, in order to encourage applications from groups who had interesting research ideas but may have had little research experience. For example, a two-phase assessment process was developed to facilitate the development of the research proposals. The first assessment stage focused on the applicant organisation; its understanding of drug issues; its links with the local community, service providers and planners; and the relevance of the proposed research to the NACD's programme of work.

Thirty-five applications were received from groups around the country. From these, eleven organisations were shortlisted and invited to attend a research training workshop to further develop their research idea. Fourteen people from the eleven groups attended the one-day workshop which dealt with issues such as literature reviews, fieldwork, research ethics, data gathering and analysis, costing research proposals etc.

Following the training workshop, the short-listed applicants submitted a fully developed research proposal outlining the aims and objectives of the research, the methodology, project management and costs. While all eleven proposals were highly regarded by the NACD assessment committee, a maximum of five research studies could be funded from the set-aside budget of €125,000. Consequently, five research grants of between €20,000 to €25,000 each were awarded. However, one study was unable to proceed due to the restructuring of the organisation and staff changes.

The research studies began towards the end of 2002 and were completed by June 2004. Throughout this period the groups were supported by the NACD Research Officer and the Research Advisory Groups established to work with each group.

Research Grant Recipients

Ballymun Youth Action Project (BYAP)

Study of the role of benzodiazepines in the development of substance misuse problems in Ballymun.

This research investigates the pattern of benzodiazepine use and misuse in Ballymun, identifies the problematic elements involved, and examines the relationship between benzodiazepine use and the use of other substances. It explores the dynamics of supply and demand in the local context, and highlights the factors that allow the continuance of a relatively high level of benzodiazepine use within the community. In this context the research explores the role played by benzodiazepines in the development of substance misuse problems in Ballymun, and identifies strategies that may facilitate change.

Kilbarrack Coast Community Programme (KCCP)

Research study on drug misuse among 10-17 year olds in the Kilbarrack area.

This study establishes the patterns and trends of drug misuse in the Kilbarrack area by young people aged 10-17 and examines their attitudes to drug use, and the risk factors accompanying their use. The study also assesses the drug use among a sample of early school leavers and examines the views of community members on the drug situation in the area.

Merchants Quay Ireland (MQI)

Drug use among new communities in Ireland: an exploratory study.

This exploratory study examines the patterns of drug use among new communities; explores the reasons and motivations for drug use; establishes risks the users may be exposed to; examines the level of awareness of health promotion/harm minimisation strategies and drug treatment services; and identifies barriers to accessing services.

Tallaght Homeless Advice Unit (THAU)

The links between homelessness and drug use.

This research examines the nature of drug use amongst the homeless population in Tallaght; explore the reasons behind their homelessness; examines the policies and practices of local authorities in relation to the housing of homeless drug users; and explores the experiences of homeless drug users with special reference to the policies and practices of homeless services.

Further information on the Community Research Grant Scheme is available on the NACD website www.nacd.ie or, by contacting:

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Acknowledgements

Talking about traumatic experiences is a risky business. The trauma may be re-lived and experiences such as flashbacks, panic attacks, feelings and symptoms associated with depression and anxiety may be experienced by the person afterwards like ripples on a pond. To endure this type of emotional stress is difficult enough for those with a home and support, but to do it alone, while managing an addiction, and often without even a shelter to keep out the weather is to enter a very painful place indeed.

Sincere thanks, therefore, to all the service users who made this study possible. Their contribution comprises the heart of this report. As far as possible, their own words have been used to give voice to their own experiences. The commitment of all who took part in this personally difficult process must be acknowledged and saluted. The best way to do this, as suggested by the participants themselves, is to work to ensure that others in the Tallaght area no longer have to go through what these people have endured and continue to endure even as this report is read.

Thanks also to the interviewees who work in agencies and gave of their time, opinions and perspectives. Many have years of experience of work in this area and that has certainly added to the quality of information in the report. We appreciate that this experience was shared openly with us.

Finally, thank you to members of the Advisory Group and staff within the Tallaght Homeless Advice Unit for the time and commitment devoted to this research.

Marie Crawley and Mary Daly

While every effort has been made to ensure that the information contained in this report is accurate, no legal responsibility is accepted by the authors or the Tallaght Homeless Advice Unit for any errors or omissions.

Members of the Research Advisory Committee:
Aileen O'Gorman, (NACD Research Officer)
John Baker, (Department of Equality Studies UCD)
Tricia Nolan, (THAU Management Board and Tallaght Volunteer Bureau)
Cathy Doyle, (THAU staff member)
Carol Delaney, (THAU Volunteer/service user)
Patrick Mc Grath, (THAU Volunteer/Service user)

Accommodation Types

Accommodation type	Description	Available in Tallaght?
Bed & Breakfast accommodation (private commercial)	This is private commercial B&B accommodation which homeless people and families are booked into by homeless services and agencies as emergency or longer-term accommodation.	Yes.
Bed & Breakfast accommodation (Health Board approved)	This refers to B&B's which are Health Board approved and house homeless people and families, usually exclusively. These are owned privately and run in liaison with the Health Board who work with them to provide good standards of accommodation.	Yes.
Transitional Housing (may be in the form of hostel-type accommodation)	This is housing for people who may have additional support needs while in transition from homelessness to independent living. This type of housing may also be used on a longer-term basis due to the long periods of time people have to wait for re-housing.	Yes.
Private Rented accommodation	This refers to privately owned accommodation which is rented out to others for income.	Yes.
Hostels	This mainly refers to emergency accommodation, usually allocated on a nightly basis.	No.

Executive Summary

Heroin – The Mental Roof Over Your Head is a research project that has examined the issues, policies and practices faced by heroin users in Tallaght and the links between homelessness and drug use. The research shows that there are strong links between homelessness and drug use – but that this is not reflected in Government policy or agency responses which in turn impacts negatively on the experience of homeless drug users.

The literature review and interviews with both homeless drug users and service providers show that, at national level, the lack of an agreed definition of homelessness has hindered the development of a coherent national policy response. There is no co-ordinated approach by the different statutory bodies and homeless drug users feel penalised and "unseen". Staff are not trained or resourced adequately and the absence of agency policies, procedures and training specific to the issue of drug use and homelessness means the quality of service is dependent on the individual encountered on the day. Information regarding services and supports is not readily available to homeless drug users.

At local level, the lack of homeless services in Tallaght, exacerbates the problem for local drug users as they are directed into city centre hostels where drugs are freely available. When this happens they lose access to the support services of the local drug clinic.

The Anti-Social Behaviour clause of the 1997 Housing (Miscellaneous Provisions) Act is problematic. It is used for eviction purposes thereby further excluding people already living in disadvantaged and chaotic situations. It does not provide emergency accommodation for drug users, and labels people as dealers (often not substantiated) which makes it very difficult to access council housing in the future. When people are evicted, all other forms of social housing are also closed to them.

The way in which the South Dublin County Council removes people from the homeless register is problematic in that clients are removed if they do not respond to letters sent out by the local authority or are in prison. Also, the South Dublin County Council Homeless Register does not accept 'c/o' addresses for applicants, which directly conflicts with the circumstances of the individual the register is intended to serve – particularly homeless drug users.

The research reflects the wide variety of issues raised in the interviews by the homeless drug users. These include descriptions of poor sleeping and living conditions, discriminating treatment by service providers, inadequate medical support, and inaccessible bureaucratic systems which have to be penetrated by already vulnerable people living in chaotic conditions.

There are many detailed recommendations in the research report but the three main areas identified are the need for:

- adequate financial and human resources;
- considered national policy co-ordination;
- improved local services in Tallaght.

National policy making, with clear universal definitions combined with local resourced services and an improved partnership approach between different agencies are recommended as the necessary elements to break the links and cyclical connection between drugs and homelessness.

Chapter 1 – Introduction

The Tallaght Homeless Advice Unit was established in 1993 to provide advice and information to people experiencing or at risk of homelessness in the greater Tallaght area. It works extensively with drug users including those who are active heroin users, stabilised on methadone programmes or those who are now drug free. In the course of its work with people who are homeless, it became clear that the experience of homeless drug users and in particular homeless heroin users differs from that of other people who are homeless. The rationale for the research project therefore is to examine the issues, policies and practices faced by heroin users which contribute to their continued homelessness. An initial overview of existing research in the field suggests that the effects of barring orders, the Anti-Social Behaviour policy and the practices of homeless services require further exploration. This research project sought therefore to examine these issues as they are experienced in the greater Tallaght area.

In the course of the field research, a number of issues additional to those which were initially being explored emerged. This was particularly the case in the interviews with service users, some of whom referred to the research interview as a welcome space in which they did not feel they were being judged or assessed. Findings from these interviews are presented in this report. Extracts from interviews are also included to afford people a 'voice' – one which is frequently absent from policy considerations.

Chapters One and Two set the research project in context by providing information on the Tallaght Homeless Advice Unit, outlining the nature of its intervention and identifying the purpose of the research which has emanated directly from its work.

Chapter Four, provides an outline of the current policies and debates in relation to the issues of homelessness, problem drug use, housing policy and social exclusion. The literature review places the issues within a social exclusion context and this framework is applied throughout the report.

The findings from the field research with both service users and providers are outlined in Chapters Five and Six. Chapter Seven draws conclusions and identifies recommendations.

Chapter 2 – Background to the Research

This chapter sets the context of the research by presenting background information on the Tallaght Homeless Advice Unit, (the organisation which commissioned the research) and the National Advisory Committee on Drugs Community/Voluntary Sector Research Grant Scheme (under which the study is funded).

2.1   Tallaght homeless advice unit

Tallaght Homeless Advice Unit (THAU) was established in January 1993 to provide advice and information to people experiencing or at risk of homelessness in the Greater Tallaght area. It provides an advocacy service offering support to people who find themselves out of home, at risk of becoming homeless, encountering tenure problems with private landlords or the local authority or experiencing difficulties dealing with statutory and voluntary agencies. It is engaged in crisis intervention work with many clients and aims to listen to and address issues as they arise. Support is also given through extensive advocacy work on behalf of clients in order to ensure they are accessing their housing and other basic human rights. It also produces user-friendly guides to homeless services.

THAU works extensively with drug users including those who are active heroin users, stabilised on methadone programmes, or those who are now drug free. It advocates on behalf of drug users on a daily basis to challenge exclusionary practices by statutory and voluntary agencies. It also works closely with a number of other services including the South Dublin County Council; the health board community drugs teams, voluntary sector drugs projects; social workers; community welfare officers; mental health services; citizens' information centres; the Tallaght Partnership and Traveller services in Tallaght.

THAU seeks to empower service users to take an active part in bringing about change, using a community development and human rights based approach. A fundamental objective of the Unit is to challenge the violation of service users' rights.

2.3   Research aims and objectives[1]

The purpose of this research is 'to undertake an emancipatory research project with a targeted group of homeless drug users which will document the link between homelessness and drug use, and which will make a significant contribution to challenging the factors that result in current and former drug-users becoming and remaining homeless'.

The objectives of the research study are:

1. To explore local authorities' policies and practices in relation to drug users focusing on:
    - What local authorities are doing to provide homes/shelter to homeless drug users;
    - What local authorities are doing to deny homes/shelter to homeless drug users;
    - Whether their policies are legal, fair/well-grounded, or transparent. In particular, the official and de facto practices relating to anti-social behaviour under the 1966 and 1997 Housing Acts will be addressed.

2. To explore the experience homeless drug users have of homeless services. In particular the study will focus on the Northern Area Health Board Homeless Person's Unit, Emergency Hostels, Transitional Housing, Health Board Social Workers, privately owned bed and breakfasts and private rented accommodation in terms of:
    - What these providers are doing to provide homes/shelter to homeless drug users;
    - What these providers are doing to deny homes/shelter to homeless drug users;
    - Whether providers' policies are legal, fair or transparent.

3. To undertake emancipatory research methodologies with homeless drug users. The research is carried out in order to make recommendations aimed at informing policy at government and practice levels.

4. To undertake primary research exploring the relationship between homelessness and drug use focusing on:
    - The nature of drug use among a group of homeless drug users;
    - How drug use leads to homelessness, and if relevant, how homelessness leads to drug use;
    - The experience drug users have of homelessness.

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1   This section is drawn from the research proposal submitted by THAU to the NACD.

Chapter 3 – Research Methodology

This chapter details the process which was followed in conducting the research from the initial meeting of the Advisory Group to the presentation of a first draft of the report. It also outlines some of the learning from the process which may assist in the design of similar projects in the future. Finally, it presents the definitions of 'drug user', 'problem drug user' and 'homelessness' which inform the content of this report.

3.1   The process

The following methodology was applied:

1. An Advisory Group was formed comprising representatives of the Tallaght Homeless Advice Unit (including two service users), a representative of the National Advisory Committee on Drugs, a member of the Equality Studies Centre, University College, Dublin and the two consultants who conducted the research. The Advisory Group met at the outset of the project to broadly agree the research brief and parameters. It subsequently met prior to the commencement of the fieldwork (at which point final lists of interviewees and interview schedules were tabled); and again to comment on draft reports. (Appendix 1 outlines a list of members of the Advisory Group.)

2. At the outset, it was intended to conduct twenty interviews with service users (homeless problem drug users) and twelve interviews with key personnel in relevant agencies, including those responsible for the direct provision of accommodation.

3. Criteria for selection of service users were agreed between the consultants and the Advisory Group. Key personnel within the main agencies and accommodation providers were identified by Advisory Group members. An important criterion in the identification of individuals was the need to involve both policy makers and front-line staff.

4. Service users were selected from THAU records and attempts were made to identify a broad range of interviewees. Considerations included gender balance, age mix, people with and without dependents, from within and from outside the Tallaght area, different variety of accommodation experiences and whether or not individuals had a history of offending.

5. Tallaght Homeless Advice Unit (THAU) assumed responsibility for contacting all interviewees and coordinating interview schedules. Letters were sent to key personnel within agencies and accommodation providers in advance of the research being conducted. This was both to solicit participation and to inform agencies of the purpose and scope of the research. All letters were followed up with telephone calls made by members of THAU staff to encourage participation and to arrange interviews.

6. Ethics guidelines, health and safety guidelines, consent forms and data protection guidelines were designed by the consultants in compliance with NACD procedures and agreed with THAU staff and the NACD Research Officer. These are included in Appendix 2.

7. Training in research methods and the agreed ethics framework and health and safety regulations were delivered to participating THAU staff by the consultants.

8. Securing participation in the research (of both service users and providers) proved more difficult than anticipated. Meeting the agreed criteria for service users also proved difficult. As a result of this and other issues (outlined below), the final number of interviews conducted was seventeen with service users and thirteen with service providers. Interviews were conducted using semi-structured interview schedules.

9. While it was intended at the research design stage that members of THAU staff participate in each interview, the logistics determined otherwise. While a THAU member of staff attended each service user interview, the interview was conducted by the consultant. THAU staff members attended seven interviews with service providers.

10. All research participants were assured of the confidential nature of the interviews at the outset. Every attempt has been made to ensure that the identity of interviewees is not evident in quotes used.

11. Detailed notes were taken during all interviews. In those with the service users, permission was sought to tape the interview, and where this was 'granted, it was recorded.

12. The penultimate draft of the report was circulated to all members of the Advisory Committee for comment and feedback, both individual and collective, has been taken into account in the production of the final report.

3.2   Learning from the process

1. At the outset, it was intended that an emancipatory research methodology be applied,[2] and this was achieved in a number of respects, including the involvement of some service users in the design and supervision of the research, the use of the research to give a voice to their perspective and the fact that they were involved in the final drafting of this report. Ideally, an emancipatory approach would involve a greater degree of partnership between service users and the researchers. However, this was not possible within the limited resources available to both THAU and the research project, especially in light of some of the other factors mentioned below.

2. The nature of the work being researched meant that it was difficult to secure participation from both service users and providers. The lifestyle of the client group is not conducive to being available for a scheduled interview – physically, mentally or emotionally. A change in circumstances at any stage leading up to the interview could result in either a 'no show' or the interviewee not being in a position to participate. This resulted in a number of interviews being cancelled at short notice and interview schedules constantly being revised.

3. Similarly, people involved in service delivery in this area of work; particularly those employed at the 'front line' are working under pressure with limited staffing resources. The participation of the THAU service providers in the interviews had a negative impact, in that it meant there was one less staff member available to deal with clients.

4. THAU experienced difficulties in securing participation of (in particular) statutory agencies in the research. The reasons why some individuals and agencies were hesitant to participate are unclear. Suffice it to say, this placed pressure on THAU as an organisation, and on the research project in terms of its ability to work within the timescale agreed at the outset.

5. Clients found that the interviews 'opened up' a lot of issues for them and needed support after the interviews have taken place. Both service users on the Advisory Committee indicated that the provision of follow on support from the THAU staff present at the interviews was crucial. This resulted in an unanticipated level of pressure being exerted on THAU staff as they had to deal with this in addition to being actively involved in the research and maintaining the regular level of crisis support offered by the project.

6. The research placed THAU in the difficult position of having to make a choice between provision of follow on support to clients who had participated in the research and continuation of its normal level of service to people who are homeless.

7. Interviews with service users would have benefited from the involvement of a former homeless drug user – somebody who was now 'out of' the situation but had direct experience of the issue.

3.3   Definitions

For the purpose of this research the following definitions have been used:

Drug user

The term 'drug user' is used throughout this report. In this context, it is understood to mean that drug use has led to the user experiencing problems, as outlined in the following definition.

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2   'Emancipatory research is the generation of socially useful knowledge within particular historical and social contexts. It is concerned with confronting social oppression. It is different from the model of social research which is the pursuit of absolute knowledge through scientific methods. It is indicative of the changed social relations of research production, placing control in the hands of the researched, not the researcher'. (Mike Oliver: *'Emancipatory Research: Realistic Goal or Impossible Dream?'*)

Problem drug user

"An individual who, as a result of taking psychoactive drugs suffers medical, psychological or social complications"[3]

Homelessness

The understanding of homelessness which informed this research is reflected in the following two definitions:

'A person is considered homeless if they "are sleeping on the streets or in other places not intended for night time accommodation or not providing safe protection from the elements or those whose usual night time residence is a public or private shelter, emergency lodging, Bed and Breakfast or such, providing protection from the elements but lacking the other characteristics of a home or intended only for a short stay"[4].'

'It is insecurity of tenure – temporary accommodation a state whereby it is difficult to do other than live day to day – not able to plan ahead'[5]

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3 Definition used in by 'Wherever I lay my Hat…' -A study of out-of-home drug users, Merchant's Quay
4 Eastern Health Board, 1999
5 Tallaght Homeless Advice Unit

Chapter 4 – Literature and Policy Review

4.1   Introduction

Drug use and homelessness have increasingly become features of modern Irish society. While each can obviously be experienced in isolation, there is a body of evidence, both anecdotal and theoretical, which links the two. The search for responses to each problem, and consequently to the two together, is most usefully located within a general body of work termed 'social inclusion'.

To be involved in problematic drug use while homeless means that an individual can be in serious need of help, yet the reality of his/her lifestyle places that individual at the edge of society. This set of circumstances presents a challenge for policy makers seeking to generate an appropriate response to this particular combination of needs.

4.2   Social exclusion

The term 'social exclusion' originated in France in the 1970's, but to date there is no universally accepted definition either theoretically or operationally (SOSTRIS, 1997; Room,1995). The understanding of social inclusion/exclusion which underpins the content of this report are based on definitions provided by the Combat Poverty Agency[6] who describe social exclusion as:

> *'The process whereby certain groups are pushed to the edge of society and prevented from participating fully by virtue of their poverty, inadequate education or lifeskills. This distances them from job, income and education opportunities as well as social and community networks and they have little access to power and decision-making bodies.'*

the report goes on to describes social inclusion as:

> *'Ensuring the marginalised and those living in poverty have greater participation in decision making which affects their lives, allowing them to improve their living standards and their overall well-being.'*

Given the widely accepted belief that those living with homelessness and problematic drug use constitute a group experiencing extreme social exclusion, the issues facing out-of-home drug users addressed in this report will be explored with reference to this concept.

In terms of the impact of a social inclusion approach on Irish policy making, in the last ten years, Ireland has seen significant progress in terms of naming, understanding, investigating and developing policy to tackle the range of issues which contribute to inequality in Irish society. As a result, key Government publications including the Programme for Prosperity and Fairness (PPF), the National Anti-Poverty Strategy (NAPS) and the National Development Plan (NDP) clearly identify the creation of a more inclusive society as one of the major challenges facing Irish society.

In addition, the Cabinet Committee on Social Inclusion and Social Policy, located in the Department of the Taoiseach, has a brief to provide a strategic focus for tackling issues of social exclusion, alienation and disadvantage. The establishment of eight pilot Social Inclusion Units in local authorities is intended to support the implementation of key elements of the NAPS locally and to ensure that social inclusion is both prioritised by local authorities and informs the way they develop policy and deliver services.

4.3   Housing – the Irish context

Ireland has acknowledged the right to housing through its ratification of a number of international human rights instruments, including the Convention on the Rights of the Child (1989) and the UN Habitat Resolution 2001.

6   www.cpa.ie

The development of housing policy in Ireland has been characterised by the social norm of home ownership. Because of this strong and culturally-rooted tradition, owner-occupation remains the dominant feature of the Irish housing sector, with Ireland having the highest rate of owner-occupation in Europe. For those who do not fit within this category the prospects are uncertain. Increased pressure from rising house prices since the mid 1990's combined with a drop in the level of social housing provision has meant that owning a home is now out of the reach of people on an average income. In 1999, the housing needs assessment showed an increase of 43% in households in need of local authority housing (since 1996).[7]

4.3.1   Social Housing in Ireland

'Social housing', i.e. housing provided on a not-for-profit basis, has been provided by local authorities in Ireland since their inception, and they still remain the key provider of social housing. Almost one third of the dwellings now occupied in the country originated as social housing.

The 1970's saw the full-scale decline of social housing across Europe, a phenomenon known as residualisation, where not only does stock shrink but the residents left in social housing estates are mainly those in receipt of social welfare payments.

While the residual nature of local authority housing makes it vulnerable to social problems the manner in which local authorities have managed their housing stock and tenants has not helped the situation. The widely held view is that local authorities have focused on the technical aspects of property management rather than managing the proliferation of social problems that came with residualisation.

4.3.2   Estate management and resident participation

As a result of the development of 'Estate Management' practices which involves tenant participation and consultation, new challenges have emerged which has served to further exclude already vulnerable people. In some instances, tenant consultation and participation, has deepened the social exclusion of people whose behaviour is considered to be anti-social or who are suspected of anti-social behaviour.

This is partly due to the competing nature of needs on any given estate. Nowhere is the conflict between competing needs more evident than in the management of anti-social behaviour on estates with particular reference to drug use. It is worth noting that while the 1997 Housing (Miscellaneous Provisions) Act put Estate Management into legislation for the first time, it did so in the context of the management of anti-social behaviour by exclusionary practices, which, it has been argued, is a negative approach.[8]

4.4   Homelessness in Ireland

Homelessness makes its first specific appearance on the Irish statute books (other than as 'vagrancy') in the Housing Act 1988, where responsibilities were placed with local authorities for the provision of accommodation to homeless people and those in sub-standard accommodation. Under Section 2, it is stated that a person may be accepted as homeless by the relevant housing authority if:

i)   there is no accommodation available, which in the opinion of the authorities, he (sic), together with any other person who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or

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

The Act also obliges housing authorities to:

■   assess the needs of homeless people for local authority accommodation at least every three years;
■   ensure that this need is adequately met;
■   have regard for the extent of homelessness;
■   undertake planning to provide for the needs of homeless people.

7   'Housing Statistics Bulletin', Department of Environment and Local Government quoted in NESF Report no. 18 'Social and Affordable Housing and Accommodation: Building the Future,' NESF, Sept 2000
8   Memery & Kerrins, 2000

Until the Housing Act 1988 was introduced there had been no proper assessment of homelessness in Ireland carried out by local authorities since the 1920's. The 1988 Act required local authorities to assess people in housing need or homeless. In 1999 the assessment showed that approximately 5,500 people were homeless – practically double the figure in 1996. Between 1989 and 1999 the number of people homeless in Ireland had increased by 250%.[9]

This whole area of statistics on homelessness is contested and controversial and becomes even more so when it comes to assessments for the Dublin area. There have been two official assessments of homelessness in Dublin. *"Counted In"* was based on surveys of individuals and families who contacted a homeless service or who were accepted as homeless by a local authority in the last week of March 1999. This survey identified 2,900 individuals (2,690 households) as homeless. The most recent count in 2002 showed a total of 2,920 individuals (2,560 households) as homeless in Dublin.

However, homeless agencies maintain that figures are much higher. They use a wider interpretation of what it means to be homeless including for instance the group termed the 'hidden homeless,' i.e., those staying with relatives or friends. The Merchants Quay Project draws attention to the fact that official assessments show that the number of families and children experiencing homelessness is increasing. Between 1999 and 2002 there was an increase of 100 families who were homeless, from 540 to 640. There was also a corresponding increase in the number of children who were homeless, rising by 15% from 990 in 1999, to 1,140 in 2002.

Merchants Quay also point to the fact that the Rough Sleepers Count jointly carried out by the Simon Community, Focus Ireland and Dublin Corporation in 2000 showed that the total number of rough sleepers in Dublin city centre was 202, representing a 60% increase on the street count of December 1997 and a 36% increase on the street count of June 1998. The total number of males sleeping rough was 163, or 81%. The number of female rough sleepers had increased by approximately 70%.[10]

It is worth noting that when the 'rough sleepers' count takes place definitions are again at issue. This study has shown that in Tallaght, there is a trend for homeless people to sleep in garden sheds, yet people living in this type of 'accommodation' are not included in the rough sleepers count.

It is clear that the numbers of homeless people are increasingly rising and Dublin in particular is experiencing unprecedented levels of homelessness. *Shaping the Future: An Action Plan on Homelessness* notes that three quarters of all homeless people in Ireland are in County Dublin, 95% of them in Dublin city.

4.5   Anti-social behaviour and the Housing (Miscellaneous Provisions) Act 1997

The mid-90's saw a 'new wave' of heroin use in Ireland characterised by the young age of those involved in it.[11] Subsequently, several factors placed drugs at the top of the political agenda.[12] These included:

- media coverage highlighting the excessive lifestyles of so-called 'drug lords';
- the rise of vigilantism on estates where local residents were organising to rid their communities of drug pushers;
- fear engendered by drug-related violent crime and murders, in particular the murder of journalist Veronica Guerin.

Among the responses to this need to control what was being widely experienced as an uncontrollable situation was the 1997 Housing (Miscellaneous Provisions) Act and its section on anti-social behaviour.

The term Anti-Social Behaviour is defined in the Housing (Miscellaneous Provisions) Act 1997 Section 1 (1) as either one or both of the following:

i)   *The manufacture, production, preparation, importation, exportation, sale, supply, possession for the purposes of sale or supply, or distribution of a controlled drug (within the meaning of the Misuse of Drugs Act 1977 and 1984).*

ii) *Any behaviour which causes or is likely to cause any persistent or significant danger, injury, damage, loss or fear to any person living, working or otherwise lawfully or in the vicinity of a house provided by a housing authority under the housing acts 1966-1977, or a housing estate in which the house is situated and, without prejudice to the foregoing, includes violence, threats, intimidation, coercion, harassment, or serious obstruction of any person.*

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9   Department of Environment Assessments 1989-1999
10 www.mqi.ie
11 O'Gorman, 1998
12 Memery & Kerrins, 2000

One of the problems in the implementation of a policy on Anti-Social Behaviour is that the classification of certain behaviour as 'anti-social' or 'nuisance' is subjective. Different people are annoyed by different things. This becomes even more subjective when it comes to deciding at what point a behaviour, which is afforded a degree of tolerance, becomes anti-social. Some theorists try to distinguish between neighbour nuisance and 'anti-social behaviour' in terms of minor annoyances as opposed to serious and possible criminal acts. When a criminal definition of anti-social behaviour is used, the question arises as to whether a housing management department is the appropriate agency to deal with criminal acts, when the police are resourced to do just that in any case.[13] For example, housing officers are expected to perform a quasi-policing function and this becomes more complicated when this process is carried out in partnership with local residents associations on estates.

The use of eviction to deal with social order problems associated with drug dealing and related activities on estates further increases social exclusion, and does no more than move the 'problem' elsewhere. It can result in those who are vulnerable because of addiction being excluded and the situation abates temporarily. The message to drug users is that their addiction is likely to lead to the loss of their home and prevent them from being re-housed; making it less likely that those who need help will seek it, for fear of being labelled anti-social.

A comprehensive study of the impact of the Act conducted by Memery and Kerrins in 2000 concluded that discretionary practices were the 'grey area' which had most potential to affect drug users. The study makes a distinction between direct and indirect use of the Act as follows:

'Direct' use includes full use of all the powers of the Act to achieve evictions, subsequent refusal to let and sell to the evictee, use of Garda checks for screening potential tenants and refusal of a Social Welfare Allowance (SWA) rent supplement on grounds of Anti-Social Behaviour.

'Indirect' use includes situations where people voluntarily surrender their keys before full proceedings are enacted. This can be because of:

- fear of being denied SWA rent supplement;
- fear of not being registered on housing lists again.

Indirect use can also result in people changing their behaviour so as not to lose their tenancy and access to SWA rent supplement or one person leaving so that the actual tenant does not lose the tenancy because of his/her actions.

The Act allows actions to be carried out to remove tenants who are engaging in Anti-Social Behaviour in the interests of good Estate Management. Although Anti-Social Behaviour relates to wider issues than drug dealing, it is mainly used to deal with drug dealing on estates.

The main findings on the impact of the Act in the Memery and Kerrins study were:

- There had been an increase in evictions due to Anti-Social Behaviour by Dublin Corporation since the introduction of the Act.
- All Dublin LAs had used the powers of the Act to check the background of prospective tenants with the Gardaí.
- The Eastern Region Health Authority (ERHA) had also exercised its power under the Act to refuse rent supplement to people evicted under the Act.
- There is no clear route to re-housing for those who have been refused access to housing lists on grounds of anti-social behaviour either because of past records with local authorities or as a result of a Garda check.
- If there is a 'refusal to let' by a local authority, *'more discretion is exercised by the ERHA in terms of SWA rent supplement'.[14]*
- In practice indirect actions taken in particular by South Dublin County Council (SDCC) and Dun Laoghaire-Rathdown County Council worked as follows: between the point at which the tenant has been told he/she will be evicted for anti-social behaviour and the actual first formal steps of the procedure, tenants may be made aware by the LA that it 'is in their best interests to leave'. This is likely to result in the tenant leaving the property thus resolving the problem for the local authority. It also means that the tenant does not suffer the weight of consequences of the Act being implemented against them. In practice this means they have some access to accommodation, with a possibility of getting rent supplement. They are, nonetheless, homeless.

13 Papps 1998
14 Memery and Kerrins, (2000) p. 22

- Between 1997 and 1999, the SDCC implemented three evictions under the 1966 Housing Act.
- In 1998, in the SDCC there were 64 voluntary surrenders and in all except five cases, keys were surrendered for fear of not receiving a conviction of anti-social behaviour and thus not being re-housed in the future.
- There is a lack of clarity with regards getting back onto a housing list following a conviction for anti-social behaviour. Dublin Corporation has a procedure in place which allows residents groups an input into decisions regarding property allocation. The potential tenant must also prove that s/he is trying to tackle his/her anti-social behaviour, typically by being on a drug rehabilitation programme.
- There is a lack of clarity about the procedures being employed in cases of anti-social behaviour and lack of information as to exactly how far the influence of residents' groups extends in terms of activity related to anti-social behaviour.
- The 1997 Act compounds the cycle of homelessness and drug addiction.

4.6   Concerns of agencies working with homeless people (In relation to the Housing Act, 1997)

With regards the implementation of the Act, the Memery and Kerrins(2000) study outlines the concerns of three voluntary sector agencies working with homeless people namely – Threshold, Merchants Quay and the Simon Community, they include:

- there would be an increase in homelessness among drug users. As a consequence, there would be an added burden on services for homeless people;
- drug taking would move from estates to streets;
- health risks to drug users who were evicted would be increased;
- the culture whereby many drug users sell a small amount of drugs to support their habit would leave them targeted for exclusion, thereby, equating this sort of activity with major drug supplying and resulting in the same consequences for vulnerable people.[15]

Threshold voiced additional concerns that:

- the standard of proof required was very low;
- the definition of anti-social behaviour was not confined to drug dealing;
- there would be impact in terms of blocking access to all housing for those evicted (refusal to let and refusal of SWA rent supplement);
- there was no provision for any other means of resolving disputes bar punitive action.

According to the study, the view of the Simon Community was that the cycle of homelessness and drug addiction was compounded by the Act. The Simon Community outlined the situation facing homeless drug users as:

- Estate Management practices make them homeless with no return route to accommodation;
- homelessness increases risk behaviour among drug users;
- many hostels will not take known drug-users;
- there is a shortage of detox services for 'No Fixed Abode' users and difficulties in accessing services associated with being outside catchment areas.

The area of anti-social behaviour represents a major challenge for policy-makers and those managing social housing on a day-to-day basis. The 1997 Act was introduced in a climate of fear and moral panic and has been described as 'a blunt instrument'[16] for managing anti-social behaviour.

When considered in the light of Government commitments to social inclusion, as illustrated above, the results of its implementation are at odds with an understanding that out-of-home drug users are doubly socially excluded. The challenge therefore lies in the need to implement a policy which is sensitive to the problems faced by a vulnerable section of the population, i.e. those with a drug addiction, while at the same time is effective in eliminating major drug dealers, those who profit from the vulnerability of drug users.

15 www.simoncommunity.com; www.mqi.ie
16 Research interview

4.7   Tackling homelessness in Dublin

The framework for addressing social exclusion in housing in Ireland has been developed through a series of policy initiatives. *'Homelessness – an Integrated Strategy'* which was published in May 2000 sets out the Government's plans for tackling homelessness. The Strategy is the outcome of the work of an inter-departmental team and intended to address accommodation, health, welfare, education and preventative measures.

The Strategy reflects forward thinking in its acknowledgement that tackling homelessness requires more than the provision of shelter. It recognises that homelessness is a huge challenge in the quest for the eradication of poverty in Irish society and that it needs to be dealt with in a coordinated way. The strategy sets out a range of proposals including:

- drawing up of joint three-year action plans by local authorities and Health Boards in co-operation with voluntary bodies, formulating a comprehensive, coherent and effective response to homelessness in their local areas;
- setting up of homeless forums in all counties, drawing membership from local authorities and voluntary agencies;
- setting up of an office with a director responsible for coordinating the delivery of services in the Dublin area;
- provision of additional current and capital funding;
- development of a separate strategy to tackle homelessness among young people.

The Strategy clarifies the responsibilities of local authorities and Health Boards. Responsibility for the provision of accommodation for homeless adults lies with local authorities and responsibility for the health and care needs of homeless adults lies with the Health Boards.

However, it is worth noting that while the Housing Act (1988) empowers local authorities to provide accommodation for homeless persons, the Health Act (1953) also puts responsibility on Health Boards to provide shelter and maintenance for any person who is in proper need of such assistance. In these circumstances, the need for an integrated approach becomes pressing.

4.7.1   Prevention – better than cure?

February 2002 saw the launch of the *'Homelessness Preventative Strategy'.*

The preventative strategy suggests that those most at risk of homelessness are those who:

- have come out of prison (having been insecurely housed prior to entering prison)
- lack personal and family support or
- have substance misuse problems.

It makes an explicit causal link between homelessness and drug use. It acknowledges that drug use exacerbates the difficulties facing those leaving any kind of institutional care (the focus of the strategy) (p8). Yet despite this, there is no action in the strategy which specifically addresses the needs of people with substance misuse problems.

4.7.2   'Shaping the future: an action plan on homelessness in Dublin 2001-03'

The Integrated Strategy (as outlined in 4.5.1) requires that each local authority produce a three year action plan outlining a comprehensive response to homelessness. As a result, *'Shaping the Future: An Action Plan on Homelessness in Dublin 2001-03'* was produced on behalf of the four local authorities. The plan addresses the needs of adults. There is a separate plan for young people.

This document is informed by two central principles:

- partnership between the voluntary and statutory sectors as central to service delivery;
- an integrated approach based on a continuum of care.

The Plan acknowledges that there *'has been a general failure by policy makers and others to make connections between homelessness and the wider world of social policy, poverty and social exclusion'(p.5).*

The Plan also recognises that:

- prevention is a key part of the plan and sets targets for Government agencies, local authorities, Health Boards and voluntary organisations in this regard;
- the underlying cause of homelessness is poverty combined with personal crisis;
- lack of appropriate services or housing options can keep people homeless;
- services available must be relevant to the needs of homeless people (it specifically refers to those barred because of drug and alcohol problems);
- the fragmented nature of existing services;
- that for many people, homelessness is a long-term condition;
- that a minority of people who become homeless because of chronic disabilities, such as, mental ill-health, remain homeless because of lack of services geared to their needs;
- the longer a person is homeless the harder it is for him/her to re-integrate into mainstream society due to institutionalisation and dependency created by hostel or street lifestyle;
- single people have particular needs because they have no entitlement to local authority housing and find it difficult to compete for private rented accommodation.

The Homeless Agency leads the implementation of the Action Plan and manages the delivery of services to homeless people in Dublin. It divides people who are homeless into two categories:

1. Those for whom poverty combined with crisis has precipitated homelessness.
2. Those that have chronic disabilities such as mental illness or alcohol dependence.

The three-year Action Plan is rolled out annually by means of a one-year operational plan. The Operational Plan for 2003 recognises that while progress is happening in some areas, there is a slow rate of progress in others. It recognises that *'it is unlikely'* that the 1500 units of housing for single people will be achieved and notes that 'settlement services have not developed at the planned pace. It also states that local responses remain undeveloped and little attention has been paid to preventing homelessness.' This has meant that emergency beds have remained blocked; people continue to spend long periods of time homeless, while responses remain centralised.

The plan stated that by June 2003 the Health Boards should have *'plans in place to address the needs of people who are homeless and have drug and alcohol addiction'* (p.20). There would be quarterly monitoring of trends and overall percentages of numbers of people coming into the system, based on a range of triggers including specifically drug abuse/alcohol addiction (listed as one category for purposes of monitoring) (p.27).

A number of problem areas for delivery of services under the Action Plan were identified, these include:

- difficulties for homeless people in accessing mainstream services (the particular situation of drug users is cited here);
- the complex range of services; an audit in 1997 showed 71 distinct services, the majority located in central Dublin and provided by voluntary organisations. Almost half were accommodation providers with the others providing food, advice, street outreach, medical, psychiatric, and statutory housing or income maintenance services. Three out of four people working in these services had no formal qualifications relevant to their work. The others had qualifications in social work, community work, counselling and psychology;
- the concentration of homeless people in the Dublin Corporation area. This is because all homeless people are referred to the Homeless Persons Unit which is a centralised service operated by the Northern Area Health Board;
- gaps in services and co-ordination. Services reflect the traditional experience of 'who' was homeless, i.e., single men. They also are dispersed. *'There are no clear pathways out of homelessness'.*

There are a wide range of actions in *Shaping the Future* which refer specifically to drug use. These range from specific targets for the increased provision of emergency accommodation to the provision of training. A summary of the points most relevant to this research study and the Tallaght area is provided below. It is important to note that a number of actions have not been implemented.

- The Health Authority to ensure that proposals for an accommodation project for up to 20 active drug users are implemented by December 2001.
- Emergency accommodation for 16-21 yr old substance users to be in place by March 2002. Nine units for men and women, with health assessment on a night-by-night basis.
- Provision by October 2002 of a low-threshold short term hostel for 10 people who are difficult to place by virtue of their behaviour or condition and are sleeping rough.
- Financial and other supports to be moved to hostels, to enable them to accommodate rough sleepers-active drug users specifically mentioned.
- Responding to people with mental health, drug and alcohol problems: Street outreach teams to have drug awareness training provided by health professionals with ongoing focus to be on assessments, harm reduction, and health promotion. Link people to out of hours assessment and treatment via on-call to existing mainstream services.
- By December 2002 to conduct a feasibility study into opening drop-in centres where drugs and alcohol could be consumed (this aims to reduce risk by taking active users out of the uncontrolled environment of the street, thus reducing the risks associated with using in this environment. Active users would also come into contact with services this way).
- By October 2003 SDCC to have provided the following emergency accommodation: 12 units for families, 16 units for young people under 28 (including provision for active drug users) and 10 units for people over 28. This accommodation is to be located in Tallaght and Clondalkin as these are main areas where homelessness occurs. Emergency units will be self-contained with flexible access hours and operate to agreed standards. Arrangements for pathways out of the hostels into appropriate housing will be in place. Accommodation for families will include access to cooking facilities.
- A refuge for six families to be provided by September 2002.
- LAs in conjunction with Health Boards and voluntary bodies will review by June 2001 the policies, practices and procedures in relation to re-housing households who have been evicted for, or have a history of, Anti-Social Behaviour.
- NAHB to complete by January 2002 an assessment of the number of people with HIV who will need supported housing over the coming 5 years.
- Examine the feasibility of providing the mobile methadone clinic, needle exchanges and referral services at appropriate locations and times including seven day access, with homeless service providers and drug services by March 2002.

4.7.3   The South County Dublin context

The South County Dublin Homelessness Forum comprises statutory and voluntary organisations that either currently provide a service to people who are homeless or whose service user group would be at risk of homelessness. It was formed to develop a plan which would outline a coherent response to homelessness in South Dublin by August 2000. This plan is the response of South Dublin County Council and the South Western Area Health Board to the Government's homelessness strategy. The definition of homelessness adopted is that used in the 1988 Housing Act. The plan drawn up aims to address the needs of homeless people in the functional area of South Dublin County Council and focuses on:

- preventative measures;
- emergency services;
- transitional accommodation;
- long-term housing;
- provision of support services;
- settlement.

The plan is intended to provide integrated local services based on the principle of the continuum of care, with among other things, a commitment to providing permanent supported housing to those who need it. At the time of writing there was no supported accommodation for homeless people available in the Tallaght area.

Part Five of the Planning and Development Act places a legal obligation on local authorities to prepare a housing strategy to cover the period of its development plan. The SDCC Housing strategy was incorporated into the 1988 County Development Plan in June 2001. A Housing Strategy Unit was established in September 2001 to implement the measures set out in the Strategy.

The Strategy states that over 80% of those making applications to SDCC for housing have yearly incomes of £10,000 or less, clearly showing that the bulk of the applicants are not in a position to buy their own homes. It is in this context that SDCC are trying to adhere to Government policy to reduce homelessness and increase social housing.

■ 15% of units provided in new residential developments will be for social and affordable housing;

■ 14,094 units will be needed in South Dublin in the period 2001-05. The Plan aims to meet this need via a variety of provisions and also in partnership with the voluntary and private sectors.

'South Dublin: A Place for People 2002-2012' is a ten year strategy produced by the South Dublin County Development Board comprising of an integrated plan for the economic, social and cultural development of South Dublin. It identifies 'Meeting Housing Needs' as a key priority theme. It supports 'Shaping the Future' in its intention to eliminate rough sleeping, and to develop services and facilities for young homeless people.

Strategic goals listed include:

■ work with all relevant agencies to explore and develop possible new initiatives that will address the housing crisis;

■ support a good standard of accommodation for Travellers suitable to their needs;

■ support the provision of homeless services and accommodation within the county;

■ improve the living environment for people with specific needs.

In addition, the SDCC Corporate Plan 2001-2006 cites the following as achievements under housing:

■ The combined development of Estate Management and subsequent adoption of the Estate Management Strategy;

■ Setting up the Allocation Support Units providing an expanded and enhanced service to the public;

■ The production of a tenant handbook and a tenant newsletter on a regular basis.

The Corporate Plan also outlines commitments to staff development and pledges to:
'Provide the necessary resources to enable our staff to continue to run an effective and efficient organisation.'

4.7.4 Tallaght studies on homelessness

In 1995, Focus Ireland published a study of youth homelessness in Tallaght which recommended:

■ that a drug treatment centre be established and resourced in the Tallaght area;

■ specialist accommodation be provided locally for drug users;

■ the development of a Foyer project for young homeless people.

None of these have been implemented and at the time of writing there remains no provision for homeless people in Tallaght other than B&B accommodation, which in effect excludes homeless drug users.

In 1999 a report was prepared for the Tallaght Homeless Advice Unit on *'Tackling Homelessness in Tallaght'.*[17] Its findings indicate that the same gaps in service provision and the same needs exist as those outlined in the 1995 Focus Report.

The needs identified include:

■ local authority accommodation suitable for young people;

■ locally based and emergency residential accommodation;

■ an adequate out-of-hours service;

■ trained personnel, resources, facilities and networking;

■ psychological service for assessment and residential care;

■ follow-up services.

The report notes that few of these needs have been addressed since 1995.

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17 O'Gorman, 1999

4.8 Drugs in Ireland: experience and response

Drug use is now a common part of Irish life and is no longer restricted to marginalised communities. There is widespread use of cannabis, ecstasy and LSD, along with tranquillisers and other prescribed drugs, both legally and illegally obtained. In Ireland, after heroin, most drug-related media attention has been given to ecstasy. There is an increase in the recreational use of cocaine which is often used with alcohol and sometimes perceived as a 'clean' and 'healthy' drug of choice.

It is currently estimated that there are 13,000 drug users in Dublin. Of these, approximately 5,000 are receiving methadone treatment. There are fewer than 150 residential drug treatment beds in Dublin city. 8,000 drug users are receiving no treatment.[18]

Current thinking on the links between poverty and drug use indicates that those who are engaged in long term damaging drug use also experience poverty and social exclusion including unemployment, poor housing, single parenthood and low educational attainment. The heavy use of opiates is consistently linked with people experiencing poverty and social exclusion.

4.8.1 Government response – The national drugs strategy

The First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) recognises for the first time that there are links between drug use, social exclusion and poverty. It also accepts the need for an integrated approach to services aimed at drug-using parents and their children.

The current drugs strategy *'Building on Experience 2001-2008'* contains a range of responses addressing the underlying contributory factors, causes and consequences of drug use and includes measures to tackle unemployment, educational attainment deficit and social deprivation. In terms of homelessness the Strategy supports the position that there is need for further research into drug use and homelessness. It refers two relevant actions to the Department of the Environment and Local Government, indicating that there is a clear recognition of the need to address the links between homelessness and drug use:

1. To commission an external evaluation of the impact of enforcement activity under the Housing Act 1997 on homelessness.
2. To monitor and evaluate homelessness initiatives in relation to drug issues.

Responsibility for overall coordination of the National Drugs Strategy lies with the Department of Community, Rural and Gaeltacht Affairs. Responsibility for the provision of treatment and rehabilitation services for drug users rests with the ten Regional Health Boards.[19] In addition, Local Drug Task Forces (LDTF's) were established in 1997 to facilitate a response in those areas where high levels of drug-related problems were being experienced. They are established as a partnership between the statutory, voluntary and community sectors. Their mandate is to prepare and oversee the implementation of action plans which would seek to coordinate all relevant drug programmes in their areas and address gaps in service provision.

4.9 Links between homelessness and drug use

The information available on the use of drugs among the homeless population is mainly derived from a number of studies on aspects of homelessness or sectors of the homeless population. Most studies have been carried out in the Dublin area thus leaving a large gap in information for the rest of Ireland. The inconsistencies in the information which is available means that it is difficult to draw definitive conclusions as to the links between homelessness and drug use, and the nature and prevalence of drug use among the homeless population.

What is evident, however, is that there appears to be a high level of drug use and associated risk behaviours such as sharing injecting equipment among the homeless population.[20] In terms of cause and effect, there appears to be some link between reasons given for becoming homeless and drug use, in that drug and alcohol use are cited by respondents in a

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18 www.mqi.ie
19 A recent Government announcement (June 2003) suggests these Boards would cease to exist. It would be important to monitor to whom this responsibility is transferred and how.
20 O'Gorman, 2002

number of studies as reasons for losing accommodation.[21] However, this is not altogether clear, as in some cases alcohol and drugs are considered together in one question.

A research study conducted by the Merchants Quay drugs project found that out-of-home drug users are both extremely vulnerable and socially excluded and that they experience additional burdens to those of other homeless people (Cox and Lawless, 1999). This is attributed to their illegal drug use, as a result of which they fall into the category of 'disreputable homeless' who tend to be badly treated in any society which operates the dualistic notion of the 'deserving and undeserving poor'. Thus they are perceived as the authors of their own misfortune because of their engagement in 'destructive and deviant behaviours', and are excluded from services.

The study concluded that *'the only categorical statement that can be made is that individuals do not cause their own homelessness'.* It further concludes that international literature demonstrates a link between drug use and social exclusion insofar as both homelessness and problem drug use are to be found among populations who are experiencing social deprivation and poverty.

4.10 The Tallaght context

The area of South Dublin covers 222.74 sq kilometres, and lies about 10 miles south west of the capital. It is bounded by the Dublin Mountains to the south and stretches from the River Liffey at Lucan through Palmerstown, Clondalkin, south to Newcastle, Rathcoole, Saggart. It includes Tallaght West, South and Central and stretches east to Templeogue and Rathfarnham.

- The population covered by South Dublin County Council (SDCC) is approximately 234,000.
- South Dublin County Council housing stock comprises approximately 11,000 houses of which around 7,700 are rented dwellings.
- Estate Management is seen as 'devoted to improving the physical and social environment' on estates and there are currently five Estate Officers.
- The South Dublin County Council is divided into three administrative committees, one of which is Tallaght (Lucan/Clondalkin; Terenure/Rathfarnham; and Tallaght).
- South Dublin County Council has five electoral areas, two of which represent Tallaght.
- In the second quarter of 2000, The Tallaght Homeless Advice Unit (THAU) were contacted by 80 people either homeless or at risk of homelessness.
- From 1997-2000 there was an increase of 32% in serious drug use in Tallaght, with most of it being in West Tallaght (Rourke 2000).

There are a myriad of agencies, strategies and plans pertinent to both South Dublin in general and Tallaght in particular. The following section is by no means a definitive account of the range of responses which have been developed to address the development of the area. Rather it offers an insight into some of the initiatives which exist.

The Tallaght Local Drugs Task Force (TLDTF) has been allocated more than €5.2 million towards both of its action plans and funding under the premises initiative. In addition, just under €2.8 million has been allocated to projects in the TLDTF area under the 'young people's facilities and services fund'. This fund assists in the development of preventative strategies through the development of youth facilities and services in areas where a significant drug problem exists or has the potential to develop.[22]

The TLDTF's Service Development Plan 2001-04, refers to Estate Management in the following way. The Plan:

- pledges its support to Estate Management initiatives, which it suggests should be extended and funded by SDCC;
- suggests there is a need to clarify the respective roles of SDCC Estate Management activities and the work of the Estate Management offices which are being developed by local community organisations within the Tallaght area;
- asserts that SDCC have not been fully supportive in this area;
- recognises the SDCC's lack of resources in this area;
- acknowledges that SDCC are an 'essential ingredient' for success in this area;

21 Holohan, 1997; Feeney et al, 2000; Houghton and Hickey, 2000; Smith et al, 2001
22 Minister of State at the Department of Community, Rural and Gaeltacht Affairs, Mr. N. Ahern: answering a Dail question

- makes provision for a comprehensive evaluation of Estate Management initiatives with *'a view to determining the most effective ways in which to organise/manage these types of initiatives and to agreeing the roles/responsibilities of the various groups and organisations which are represented on the Estate Management committees'*;
- states that SDCC need to enforce Anti-Social Behaviour provisions contained within the 1997 Housing Act;
- proposes that SDCC should work closely with community groups in *'identifying tenants suspected in being involved in drug dealing, in accumulating evidence about their drug dealing activities, and in taking appropriate action in evicting these tenants (if there is strong evidence that they have been engaged in drug dealing activities)'*.

It is clear that there are serious issues pertinent to drug related activity and addiction in communities in Tallaght and that this has been recognised and responded to at national and local level. It is the *nature* of the response which is problematic for vulnerable drug users. The response to the entwined issues of drugs and homelessness needs to be developed jointly between those working in either field, to take into account the complexity of this overlapping area of need.

4.11 Local authority procedures

One of the objectives of this research was *'to explore local authority policies and practices'* in relation to drug users. However, it became clear in the course of the research that the absence of written policies and procedures is one of the main problems in the area of homelessness and drug use. This section therefore, in the absence of specific policies in relation to drug use or homelessness within SDCC refers to publications, procedures and systems within the Council relevant to issues of accommodation, housing, tenancy and anti-social behaviour. Specifically, it presents information on the SDCC Tenant Handbook, the Allocations Support Unit, Scheme of Lettings Priorities and the rules of conduct for officers of local authorities.

4.11.1 Tenant handbook SDCC

The section on anti-social behaviour states that *'many offending tenants have had their homes re-possessed'*. The first line of the policy includes the phrase; *'if you are the subject of a complaint from your neighbours'* without further definition of the nature of the complaint. There are other features of relevance in the SDCC Tenant Handbook, namely:

- drug dealing is the primary listing under what is regarded as Anti-Social Behaviour;
- individuals are assured of confidentiality, but this is lost if they are under pressure to take an excluding order. The provision states that the Allocations Support Team will investigate the complaint and *'refer it to Gardaí, mediation services or relevant agency'*;
- there is an emphasis on the fact that the Council may not know about anti-social behaviour or empty properties and rely on tenants to keep them informed.

4.11.2 Allocations support unit

The Allocations Support Unit was established in SDCC in 1997. It deals with the Scheme of Lettings Priorities. This sets out how points are awarded for lettings. Time on the Housing List has recently been amended to award more points to reward those who have been waiting for the longest period of time.

Responsibilities of the Unit include:

- processing applications for housing accommodation, allocating new lettings and casual vacancies;
- maintaining the Housing List;
- processing applications for transfers;
- processing applications for overall priority as homeless;
- investigating complaints in relation to Anti-Social Behaviour and vetting of prospective tenants.

It is the role of the Unit to investigate complaints of Anti-Social Behaviour and take appropriate remedial action. This may involve the initiation of legal proceedings against offending tenants and the carrying out of evictions where no other solution can be found. The Unit works closely with the Gardaí and Health Boards and has a role in carrying out pre-tenancy checks on prospective tenants to ensure there is no history of Anti-Social Behaviour. The Council also consults with approved residents groups regarding prospective lettings.

4.11.3 Rules of conduct for officers of local authorities[23]

The Rules of Conduct are wide ranging and includes reference to contracts, money, and staff behaviour etc. The expected code of conduct in relation to dealing with clients is outlined below:

- Local authority Officers are *'well aware of their duty to deal with members of the public with utmost courtesy and impartiality;'*
- *'The high standards of the local authority service in these matters should be scrupulously maintained';*
- Officers are exhorted to bear in mind their obligation to act with due courtesy and consideration in all official contacts and to *'avoid any suggestion of prejudice';*
- *'Freedom from prejudice in official contacts is a fundamental ingredient of the integrity expected of public officials.'*

Overall, the SDCC has a range of comprehensive policies and procedures for the manner in which it deals with its clients. The challenge for any local authority in implementing these is the extent to which the interpretation applied is flexible enough to deal with the complex and often conflicting set of problems it is faced with. The absence of polices to address the specific needs of disadvantaged groups within society, such as out-of-home drug users, means that generic procedures and processes will be applied. In terms of attempting to deliver an effective equitable service which meets the specific needs of individual clients the challenge lies in ensuring that individual interpretation is sensitive to these needs.

4.11.3 Rules of conduct for officers of local authorities[23]

23 www.sdublincoco.ie

Chapter 5 – Interviews with Service Users

5.1   Introduction

Engaging in interviews on this subject matter was difficult for the service users, as it involved re-visiting and exploring extremely difficult times in their lives. In many cases, the interviews became emotional experiences as they recalled past events. The interviews lasted an average of one and a half to two hours. Moreover, many of those who took part in the study (11) were experiencing homelessness when they volunteered their time and spoke so openly about their lives.

The interviews were conducted on a semi-structured basis. A question asked by all interviewees was *'will this make a difference?'* Their motivation was to bring about change so that others would not have to go through the things they had gone through. This was remarkable in its consistency across the whole group.

> *'Something has to be done in Tallaght – it wouldn't be for me but it would help the up and coming generations'.*

The complex, inter-related and inter-weaving nature of the issues addressed in the course of these interviews sometimes resulted in multiple issues being dealt with in response to an individual question. This resulted in similar information emerging under different topics. Furthermore, distinctions between issues such as initial causes of homelessness set against sustained causes of homelessness are sometimes subtle. While every attempt has been made to remove overlap in the information provided in the following chapter there may be instances where information appears to replicate that which has preceded it.

5.2   Profile of interviewees

Seventeen people were interviewed, nine of whom were men (who between them had ten children) and eight of whom were women (who between them had 17 children).

Table 1: Age profile of Interviewees.

Age	F	M
20-24:	5	1
25-30:	2	2
30-35:	1	5
36-46:	0	1
	8	**9**

Amongst the group of interviewees, there were a total of 27 children; 16 were aged four and under, seven were aged 4-8 and four were aged 8-11.

All 17 interviewees were from Dublin and from the Fingal or South Dublin County Council area, the majority of whom (13) are from Tallaght, see table 2.

Table 2: Place of Origin

Place of Birth	F	M	TOTAL
Born/raised in Tallaght	6	7	13
Born outside Tallaght/within Dublin	2	2	4
			17

Fifteen of the seventeen interviewees were on treatment programmes (methadone maintenance), broken down as follows: Trinity Court (2); St Aengus (1); Millbrook Lawns (6); JADD (2); mobile clinic (2); Fettercairn (2).

The average age of the interviewees when they first experienced homelessness was 20. The youngest age on first becoming homeless was 11 and the oldest was 44. Incidents where respondents were out of home before 15 years of age were as a result of the family having to flee from domestic violence.

The average length of time being homeless was 4.1 years. The shortest length of time any of the respondents was homeless was 3 months and the longest was 13 years. The accommodation arrangement of respondents on the night of interview are laid out in Table 3 below:

Table 3: Accommodation arrangement of respondents on night of interview

B&B (HB)	Hostel	'Crashing' with relatives/friends	Family home	Rough sleeping	Transitional Housing	Private rented[24]	Own tenancy[25]	Total
3	2	1	1	3	3	1	3	17

Note: Shaded cells indicate 'homeless' at time of interview

Table 4 outlines the number of the interviewees by gender who have served a prison sentence or who are ex-offenders. These figures show that 7 out of the 17 respondents have been within the criminal justice system at some point while being homeless. The figures also highlight the fact that men are more likely to be serving sentences while women are more likely to be given non-custodial sentences. Only one out of the four women who had committed offences has served a prison sentence, compared with six out of eight males. One man reported injecting heroin for the first time while in prison.

Table 4: Number of ex-prisoners and ex-offenders

	Total	F	M	Not Applicable
Ex-prisoner	7	1	6	10
Ex-offenders	5*	3	2**	12

* two of whom were currently on bail or had outstanding warrants

** one of whom was also an ex-prisoner

5.3   Experience of homelessness

When asked specifically about their experiences, respondents initially focused on the physical conditions they had lived in, along with an outline of the emotional consequences of their homelessness. Some of the issues, which emerged from the discussions on people's experience of homelessness, also included:

- That homelessness had been experienced as a child (under 16yrs)
- That being homeless with children worsens the experience
- That homeless episodes were numerous – ranging from two to countless
- That the stability experienced in accommodation had an effect on how people viewed their situation. For example, some thought that staying with family members, in B&B's, transitional housing and in one case in prison does not constitute homelessness.

5.3.1   Physical Consequences

Physical accommodation included 'crashing' with friends and relatives, staying in hostels, staying in transitional housing, squatting, rough sleeping, prison and B&B accommodation (taken to mean anything from Health Board approved emergency accommodation for people who are homeless to commercial hotels and B&B's).

This would seem to indicate that the definition of what it means to be homeless for the respondents rests on the notion of having a place to stay where you can feel safe and secure and will not be asked to leave, coupled with having a level of stability coming from good support systems such as family and friends.

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24 Had previously been homeless and was a client of THAU
25 Had previously been homeless and was a client of THAU

Some described periods spent in emergency B&B accommodation in ways which indicated they did not think of it as temporary. These were people who had been in a particular B&B for more than three months and felt settled there, with some level of support being given by staff. Children attended school locally and there was stability in drug use.

Living in transitional housing was experienced as stable accommodation with the respondent who did not regard themselves as homeless:

> *'I kind of don't think of myself as being homeless now, but really I suppose I am, amn't I? I could still be kicked out in the morning and be back at square one.'*

Rough sleeping was described in detail with experiences including, sleeping under trees, in building sites, in sheds (including with a young baby), on rooftops, in disused buildings and railway carriages, in vehicles, in Bus Aras, in tents on waste ground and parks, in shop doorways, under bridges, and on church steps. People described staying in squats which varied from boarded up houses in Tallaght to an empty church in the City. All respondents had some experience of rough sleeping. All also had experience of having to walk the streets during the day because of living in hostels where you were out all day and in at night or because of being in different accommodation from night to night.

> *'Sunday is hell day in Dublin. Sabbath – it's more like black Sabbath for the junkies 'cos there's nowhere to go. That's the day people are most likely to do something desperate.'*

> *'If you sat up (in Bus Aras) and looked like you knew what was what and could tell them what bus you were catching, you could stay there in the day, unless they sussed you out and you had to leave.'*

> *'I was sick and cold so I tried to stay in casualty to keep warm but they threw me out onto the grass outside.'*

> *'Sleeping in a shed freezing and knackered, shattered, with a door not even locked on the shed, freezing and draughts.'*

> *'It's rough and it's cold and I would have to sleep with one eye open. It's rough and its cold and its dangerous.'*

> *'We slept in the car for ten nights with the kids.'*

> *'I woke up and I was shivering and the snow was on me feet where they were sticking out of the shelter. I walked around for hours trying to stop the cold and shivering. I thought I was dying and I wasn't even afraid because it would have been easier to handle.'*

> *'It's not a nice experience 'cos we often slept out there on the church steps and you know in the middle of the night you get all sorts of people coming in, people who are mad on the drink and there are fights and people robbing other people's stuff and people who are not even homeless, they go robbing the homeless people's sleeping gear. It's a hard life.'*

> *'Exhaustion. On the move all the time. On O'Connell Bridge early in the morning begging with the dog.'*

> *'It's very hard especially with a child, when you have to get out at 10 o'clock in the morning and walk the streets all day. I get embarrassed when I go into cafés and that to get some food and they ask me to leave because they don't like the look of me and think I am a junkie... it is very embarrassing. And when you have no money and that I find it gets me down.'*

> *'Terrible places – no running water or light just people shooting up gear.'*

5.3.2   Emotional consequences

The emotional state experienced by the respondents was characterised by loneliness, depression, and isolation. The experience was one of being trapped with few exits and most of those blocked if you were a drug user.

> *'Lonely. A horrible existence.'*

> *'It's a circle and you just go round and round.'*

'Lonely, looked down upon by others, wanting to get washed and clean and nowhere to do it, I was living in a derelict house and ended up with pneumonia.'

'Feeling bad about yourself, boredom and having time on your hands is a big problem when you are homeless. Take drugs to escape the pain.'

'I am alone all the time.'

'You feel like you are on the moon but there's people around you. It's a constant state of depression.'

'It was a nightmare – really it was. I hated dragging the kids here and there on buses in the rain, sitting around waiting on a phone call to hear where you're gonna be that night 'cos you haven't got a clue where you will be sleeping. One night we had to sleep in a van with the three kids.'

Despite the conditions people endured and the obstacles faced, there was evidence of a community spirit which expressed itself in looking out for others who were new to the scene. Anxiety about the future of younger siblings who were getting into drugs was also expressed:

'It's my little brother I am worried about. I can just see him getting into it all and he won't know how to handle it.'

'I sleep with a few others under the trees; I hate the creepy crawlies at night, crawling over you. It's dangerous too out there at night. There was a young girl near us, and I wanted to see she was ok 'cos she was new and no-one knew her. She was on her own but I didn't go beside her, just kept an eye on her, like 'cos anything could happen and I was afraid she'd be raped or something, out there on her own.'

A network of support which out-of-home drug users call on was described. It was chiefly made up of the people themselves and their relatives and friends. Some voluntary sector services also play a crucial role in providing emotional support, befriending and helping with the essentials such as food, shelter, a place to wash, somewhere to get warm, contacts for accommodation and help with drugs.

'I used to come here (THAU) every day, just to talk and you could look at the flats in the paper and make phone calls.'

'I will never forget the tenner she gave me that day. I was completely broke. It meant so much to be trusted like that.'

'If it wasn't for me mother I don't know what would happen to me.'

5.3.3   Reasons for homelessness

For respondents, when it came to talking about how they became homeless to begin with, going into hostels was seen as an option to leave home, and get away from abuse and family problems. At first, they found it a great freedom to be out of home and away from home pressures. Those who reported this were women, who had their first experience of homelessness as teenagers some of whom were escaping homes due to abuse. They were also early users of 'benzos' and heroin:

'I was taking valium at 15 and gear because I just wanted to be happy.'

However this initial sense of freedom quickly faded as the reality of the lifestyle began to bite. This sentiment was expressed mainly by women, who found that becoming a mother changed everything in terms of how they experienced homelessness. They no longer felt free, but rather felt a sense of responsibility that could double as a motivating factor for seeking help with cutting down on their drug use.

5.3.4   Complicating factors

For those who had problems to cope with in addition to being out-of-home drug users, the experience was doubly difficult. Not being able to read or write (or to have a very basic competency) was an enormous source of frustration and disempowerment given the constant requirement to complete forms to access services.

Women with children reported the lack of children's facilities and places for people with children to go as a major problem. One woman described how *'it broke (her) heart'* to discover her little girl having a conversation with her reflection in the mirror because there were no other children for her to mix with. They were living in a B&B, and although the accommodation was adequate, there was no 'concept of care' for the people living there built into the arrangement. It was designed to be a short term arrangement – meeting the need for people to have a roof over their heads. Those living in such accommodation on a long-term basis found it difficult and felt their children suffered from the isolation.

> *'There is nowhere for them to play and no toys and that. You are trying to keep them quiet the whole time in case they say you have to leave because the kids are too noisy.'*

One respondent who was escaping domestic violence referred to a problem she encountered as a drug user on a methadone programme. She spoke of a situation in a refuge where her vulnerability increased as a result of the way in which staff supervised the taking of methadone.

> *'She just called to me in front of the whole place saying 'its time for your methadone' as if I was not entitled to any privacy at all and as if my addiction was everyone's business. After that I had to leave the place and go back home again.'*

5.3.5   Awareness of where to access services

Eleven of those interviewed had trouble finding out what to do and where to go upon finding themselves homeless. Information on what to do and where to go upon becoming homeless was reported as being most readily available from other people who were homeless, or had been homeless, rather than from agencies and service providers.

> *'I didn't know where to go for help – I could get drugs quicker than help.'*

> *'I was four months homeless and a guy on the bus told me about Charles St.'*

> *'The first six months are the worst. You don't know where to go or what to do.'*

> *'It's the other people I got to know at Wellington Quay who are homeless and they tell you where to go when we're waiting to be seen.'*

One respondent was living in a shed in Tallaght and going to work on a building site, not knowing there was any help available. One woman who had been a tenant of SDCC for five years did not know her rights as she had never been issued with a tenant handbook.

5.4   Experience of drug use

5.4.1   Experience of alcohol addiction in the family home

Alcohol addiction was a feature of life in the family home for almost one-third of the respondents. Of these, one and sometimes both parents suffered from alcoholism. Whether or not a parent had an addiction problem was not a specific question asked in the course of the interview but this information was volunteered in connection with why people became homeless. A specific question on the subject may have yielded a higher percentage.

5.4.2   Early experience of drug taking

Drug taking from the age of 11-14 was reported by two of the respondents. The most common drugs here taken were tablets and cough mixtures along with smoking 'hash'. The easy availability of prescription drugs in families was cited as part of the reason for beginning to experiment with tablets. Other reasons for starting to use drugs varied from 'getting the buzz' and enjoying it, to wanting to escape a stressful situation.

> *'When I was an 11 year old making me confirmation I was already scoring and using drugs – DF 118's, DHE 60's, palf and dic.'[26]*

> *'I started taking drugs at 12, at 15 I was homeless and at 16 I was mainlining heroin.'*

26 opiates – painkillers

'The first time I took it I felt great. Everything went away. Little did I know then that I had put my first foot on the road to Hell – and they only charged me a tenner.'

5.4.3   Current experience of drug taking

All the respondents had experience of intra-venous drug use, the main drug being heroin but there was also reporting of intravenous heroin use along with cocaine (speedballing) and intravenous use of Temazepam along with cocaine. Heroin overdose resulting in hospitalisation was reported by five of the respondents. The higher cost of maintaining a cocaine habit was referred to and six of the respondents suggested their cocaine use would be higher if it could be afforded.

The range of drugs used by interviewees includes; cough mixtures, tablets, (benzos) hash, methadone, heroin, cocaine, speed, ecstasy tablets, acid tabs, rohypnol, alcohol. Alcohol was included in the categorisation of drugs in the same way as any other substance.

Taking drugs in a group was reported as common practice – it is part of the sub-culture of homelessness and injecting drug use. Group drug use was also reported as common practice while staying in squats.

Feeling out of control around drugs was primarily associated with injecting heroin. The transition to using heroin intravenously was strongly associated with moving onto the homeless scene, in particular with hostels and rough sleeping. In the main, the first experience of heroin was smoking it, often prior to being homeless, followed by intravenous use when homeless.

5.4.4   The reasons for drug taking

Homelessness clearly contributes to both the nature and extent of drug taking. The link between homelessness and drug use is dealt with in detail in section 5.5. The reasons outlined below are those reasons identified which are unrelated to homelessness.

Feeling good and being able to cope was exclusively associated with being able to maintain a drug habit. When people were feeling sick or unable to maintain their habit they were not interested in anyone else's experiences or in socialising. Not having to score drugs because of being on a programme was considered the best option for those who felt they had been addicted for so long they would never be drug free.

'The drugs are always there – it makes no odds I could be doing a chemist and be flying for a couple of weeks. It wouldn't bother me if people are explaining where they are coming from and saying that they have been stoned all week,– I might say, yeah, I've had a good week meself or a good two weeks or whatever, but if I'm sick and someone says to me – oh I had this yesterday – I would say 'look no I don't want to know' and I'd say 'come back to me when I have me own head together' and tell me this or that.'

Interviewees described the morning as being the most difficult time of the day. They referred to needing something to wake up to so that they would 'feel okay'.

'I was used to having methadone at 10 o'clock in the morning and waking up and having 5mls of naps and rohypnol in the spike on me locker.'

Others referred to increased confidence levels:

'I became emotionally as well as physically dependent on it.'

'The first time it was euphoric and I thought this is great.'

Other reasons for drug use were cited, including:

- Peer pressure;
- Impressing one's partner;
- Keeping warm when sleeping rough (all respondents referred to this);

- Enjoying the high/buzz;
- Easing the boredom associated with being homeless.

5.4.5   The consequences of drug taking

The combined consequences of homelessness and drug taking are dealt with in detail in section 5.4.

A couple of consequences related just to drug taking were also cited, including;

- Being pregnant and taking drugs puts the baby at risk. Women whose babies were born sick as a result of their drug taking experienced shame and guilt. Even where children had other illnesses not associated with parental drug taking, parents tended to blame themselves for the suffering of their children. They subsequently prioritised care of their children over drug taking.
- Having direct responsibility for children reduces and modifies drug use;

   'Having her saved my life. It made me realise that I am responsible for her now. What I do affects my family.'

5.5   Links between homelessness and drug use

Respondents clearly linked homelessness and drug use in a variety of ways:

5.5.1   Losing contact with drugs services

Some respondents spoke of losing contact with drugs services and/or coping with their drug use because of having to move out of the area for accommodation. As mentioned earlier, more than three quarters of the sample interviewed are on treatment programmes, the majority of whom are being treated in Tallaght (six people are being treated by a GP). All but two interviewees were on methadone maintenance.

Two interviewees were not on programmes, but were in contact with drugs services. They said they were not on a programme because of having to move to town for emergency accommodation. This meant they were outside the catchment area of the drugs service previously attended. Others cited this as a difficulty they had encountered in the past (prior to getting onto a programme). These respondents linked their homelessness with either disruption or prevention of access to help with their drug use. This was particularly the case when they had been attending a local service and had to move away. Interviewees found that if they were placed far away from Tallaght it was difficult to maintain the links with support in the area. This left them without support during a time of heightened vulnerability.

5.5.2   Being moved out of more stable accommodation

When interviewees were settled in stable or controlled accommodation with support and structure in their lives they reported that their drug use was also more stable. This stability was linked with B&Bs, supported/transitional accommodation and returning to the family home, where there was zero tolerance of drugs. The biggest threat to this stability was being moved back into an environment where drug taking was the norm. This could happen in two ways:

- firstly, being resettled or moved before being able to cope with the pressure exerted by drug-using friends. The fear was that they would come to their new home with an expectation that drug taking would be permitted;
- secondly, being moved into new emergency accommodation where drug taking was prevalent and drugs easily available.

5.5.3   Hostels – 'Full of drugs'

Emergency hostels were clearly identified by all interviewees as the primary risk accommodation. They all classed hostels on a par with rough sleeping in terms of exposure to drug dealing and using. All interviewees repeatedly stated that their drug use escalated in hostels. Some suggested it was worse than rough sleeping because of the added pressure of trying to cope as an active user within the system. Most associated hostels with their most chaotic periods in terms of drug use.

Interviewees identified a number of reasons why they identify hostels as the highest risk accommodation for drug users. These include:

- drugs being sold in hostels;
- there are no drug-free hostels;
- intimidation by other drug users if money is owed;
- there is a culture of drug taking in the hostels;
- drug users are feared and disliked by other hostel dwellers which adds to the sense of isolation. This in turn can lead to escalation in drug use;
- the fact that so many drug users end up in hostels.

'I had my first turn-on with gear in the hostel when I started to mainline.'

'I don't want to be in hostels – they're too much for me. I'll only end up strung out on gear again and that's the last thing I want after going so far. It's just bringing me down to level one again and I'll never get me family back.'

'I never stayed in a hostel and I wouldn't either.' (This interviewee was a rough sleeper').

'They are full of drugs.'

'I was on a methadone programme but I ended up going back on heroin because of being in the hostels and I got bullied 'cos I was on tablets as well.'

5.5.4   Management/supervision of methadone in hostels and refuges

Interviewees referred to the management of methadone taking in hostels and refuges. A situation was described in one refuge where the manager had agreed to supervise the methadone and hold it safely. However when the client was moved (because another family member was moving into the refuge) management in the second refuge refused to hold the methadone on the premises and insisted that she attend the mobile clinic locally. As a consequence of this combined with the fact that it had been difficult to get the methadone takeaway in the first place, the client went back to a violent domestic situation.

Incidents related to drug taking also disrupted stability in accommodation. This could be as a result of relapse because of active drug users coming into the accommodation or because of a pressure such as illness of a family member. It could also be the result of being moved on, having been 'found out' as a user (while being given a myriad of reasons as to why the move was happening).

'She said that she had the room booked by someone from ages ago, but when I went up to pack my stuff I could tell that she had been in my bag because it wasn't the way I left it, and the appointment card for the clinic was near the top.'

'Suddenly they said that they didn't take couples but we had been there for three nights and there was no problem. Then another girl said they were in our room and saw the phy in the fridge.'

When evictions or 'week-long bars' were enforced, interviewees said they had the effect of pushing them back into the 'circle' of the hostels. Here they were faced with the highest risk of exposure to drug taking and easy access to drugs or with rough sleeping.

Those who had this experience following a period of stability were particularly bitter at what they felt was the lack of willingness on the part of accommodation providers to accept that everyone will falter at times. They spoke of a lack of understanding of the vulnerability of users when dealers come into the environment. They felt they must never slip and that if they did the consequences were extremely grave. It would have the effect of putting them back as though the period of stability and progress had never occurred. They felt they were being watched all the time and would be thrown out for the slightest reason. As a consequence, when they were getting into trouble or temptation around their drug use they felt they could not approach the staff for support – for fear of losing their place.

'I really was sick about being evicted. I was there a year and a half and I liked it. I was doing ok, but when they found the lid of a spike, I got the blame and was thrown out. I just went out then and got me head wrecked. They said I could come back in a week and go for an appeal but what was the point. Once you are back on the streets a week it is like six months.'

5.5.5   Being trapped in the circle

Being trapped in the circle of drug use and homelessness was spoken of by all respondents in one way or another. Their description was of a process and a system, which, once they were in there, was like a series of tunnels which all led into each other. Some tunnels were drugs related and some related to homelessness – when they were in there, they had to deal with the consequences of each or a combination of both.

Whether drug use is the cause of homelessness or not, interviewees suggested that once people are living in the emergency accommodation system, entering a world of heavy and indiscriminate drug use is inevitable. Several reasons were given for this:

- vulnerability to dealers due to inexperience:
  'They're there all the time in the hostels and waiting outside when you go in and when you come out, and even some of the staff are dealing – what are you supposed to do?'

- taking drugs to blot out the pain of desperate situations. All interviewees referred to feeling so low – they took drugs to escape the reality:
  'I just wanted to get out of it. I didn't want to face it. I'd wake up, say 'I'm Homeless' cry, panic, get drugs and drink and just try to block it all.'

- having to be part of a crowd in order to survive, and having to do what the crowd does:
  ''Cos if you're not taking drugs and they're taking drugs they're saying 'what's this fuckin gobshite at? You are either in with the crew or you're out of the crew... some people are easily led.'

  'You can't avoid it because you are with a crowd and you are either with them or not, so you can't say 'see you later' when they go on the rob or whatever because you might need them later and that's how it happens.'

  'It was cool to take heroin. All the cool heads were doing it. We were all in it together.'

  'Because it is so lonely and scary when you first go there you need to link in with others for safety and company and to cover your sense of vulnerability, and once in with others who are taking drugs, it is not possible to stay part of the crowd and be drug free.'

- needing to take drugs to stay warm or to sleep:
  'On the streets you just take gear to keep the cold out.'

  'Rough sleeping you take drugs and in particular benzos and heroin to get to sleep.'

  'Your first priority is your addiction so you have to rob to get money for it-it's not easy but that's how it is-the heroin blackens out the homelessness and that's why so many are on the benzos too it makes you sleep at night it's worst at night.'

- being in a tenancy – young and unsupported because:
  'The people you knew on the homeless circuit want to crash (stay) with you and you find it hard to resist when they are doing drugs'

5.5.6   Lack of emergency accommodation in Tallaght

According to interviewees, having to go to the city centre for accommodation increases the dangers faced by Tallaght people who describe themselves as different and unwelcome on the hostel circuit.

'They don't like us and they tell us to go back out to the mountains.'

Repeatedly, respondents identified the lack of provision for homeless people in Tallaght as a link between homelessness and drug use. They got involved in the drugs scene or more serious drug taking because of 'having to go to town':

'You're forced to go into town because there is nothing in Tallaght and it's downhill all the way from there.'

'The first six months are the worst until you get more used to it. I had to hang with a crowd and there was hassle with older men taking advantage of you. I was just a young girl. And then you get roped into things – drugs and that.'

'It is impossible for a young fella from Tallaght to be in town homeless and not start using. Every time you go in and out of the hostels you have to run the gauntlet of pushers saying 'here young fella – are you looking – are you looking.' They can spot you a mile off. Any young fella who goes into town will be using within two weeks.'

5.5.7   The general environment

Interviewees referred to the fact that homelessness results in people taking drugs because they are constantly available in the 'homeless' environment, especially in the hostels. Some referred to the fact that they are inextricably linked:

'They go together.'

'If I wasn't homeless I wouldn't be on drugs. I had money in my pocket and got offered drugs so…'

'It was hard because everybody you bumped into was selling.'

5.5.8   Additional factors

Some interviewees referred to having 'time on your hands' and taking drugs to 'pass the time', associated with being in a situation where, from day to day, interviewees were waiting to see whether and where they would be accommodated that night or whether they would be rough sleeping.

'Being on your own you get in with people who are using drugs. There were 10 and 11 year olds using heroin because they had nothing else to do.'

One interviewee referred to the difficulties which arise 'if you get labelled' a dealer:

'When a person is labelled as a drug dealer they are not going to be considered for housing – one thing blocks the other: because you cannot get a decent place to stay your habit is affected and it gets larger and more out of control, and so you are less able to deal with the homelessness. When you are in this state you cannot deal with your habit because you have to be willing and motivated to tackle it, and this is impossible when you are homeless.'

Only one interviewee offered a different perspective in relation to the links between homelessness and drug use:

'There are no hard and fast links, because plenty of people take drugs at the weekends when they go clubbing, and it doesn't make them homeless.'

5.6   Drug Use – Does it cause and sustain homelessness?

The relationship between drug use and homelessness is quite a complex one. In addressing the issue in this research, two separate questions were dealt with. The first was whether drug use contributes to homelessness in the first place and the second was the extent to which homelessness is sustained by drug use.

5.6.1   Initial cause of homelessness being drug-related

Interviewees made a clear connection between the fact that they were using drugs and subsequently becoming homeless. They referred to the pressure exerted on all aspects of life by drug use and the 'knock-on' effect on family relationships, work, educational opportunities, health, fitness, social and emotional networks –all, or any of which, may contribute to becoming homeless. Over half of the respondents referred to the fact that their families could not cope with their drug use and they blamed themselves and acknowledged the consequences:

'Me mother said she was a bad mother but she wasn't – it was me who let her down. I wanted to take drugs and she couldn't understand – she was afraid of the spikes and that, but she is starting to understand it a bit better now.'

'They didn't say it was for drugs but I knew. They'd been saying 'stop it or else' for so many months and I got so many chances.'

Some interviewees referred to heroin use as the reason for being 'thrown out' by families, adding that they had tolerated cannabis and some level of benzo use.

Other explanations on how drug use contributed to homelessness include:

- eviction from a tenancy for Anti-Social Behaviour;
- relationship breakdown as a result of drug use;
- loss of house as a result of drug use (this was a privately owned house which was sold after a relationship break-up due to heroin use which had begun in prison, prior to that there was no history of drug use for this respondent).

5.6.2   Sustaining homelessness

Interviewees were asked to comment on whether drug use either sustained homelessness or prevented people from getting out of being homeless. Responses clearly indicate that it does both.

One interviewee referred to a situation in which an individual 'being labelled' a drug dealer caused a family to be separated, rent allowance to be denied, and being barred from B&B accommodation. The family *'were split up by the Homeless Persons Unit refusing to accommodate'* the man on grounds that his landlord accused him of being a drug dealer. Having slept with his family in a car for ten nights, the Homeless Persons Unit still refused to accommodate him on grounds that he posed a risk to other families. The man in question had never had a drugs conviction, but felt he was being blocked from services because the landlord had known him to be a user.

Others referred to the fact that any income they had was more likely to be spent on drugs than used to find accommodation. Also, 'scoring' and getting money for drugs becomes the priority:

'You are so focused on getting to score drugs that you cannot think of anything else. You can't start doing anything for yourself.'

'The main focus was keeping yourself supplied with heroin and nothing else mattered. There were no bills to pay, and nobody to look after except yourself.'

'All you want and can think about is a fix. That is the centre of your life. It is all you can think about. It makes your world go round.'

Reference was made to the difficulty of living in city centre accommodation combined with availing of a Tallaght based drug treatment programme. Some hostels stipulate that if a resident fails to return by a certain time, their 'place' is lost. This can be problematic if there is a delay at a Tallaght based drug treatment centre.

'They keep you late and even though they know that you have to get back to town or you won't get in anywhere still they don't help you so you get the methadone but you end up with nowhere to go that night if they keep you waiting too long. They would say enjoy the walk home lads knowing we had nowhere to go.'

'I can't get it together what with living rough and being addicted to different drugs, and they see you as a troublemaker because of the drugs.'

All but one of the respondents referred to being evicted from hostels and B&B's due to drug-related incidents:

'I was back to square one and I had nobody. I lost any ground I gained.'

'Every time you have to go back to 'Start' again.'

'They threw me out after I told them I was a drug user, so that I could get help and they told everyone else too so I couldn't get in anywhere.'

A number of other reasons why drug use contributed to people staying homeless were also cited, including:

- becoming ill and *'all you could think about was scoring drugs to make you feel better'*;
- drugs causing illness and *'watching your health became your priority'*;
- family support and the provision of accommodation being conditional on being *'clean'*;
- the difficulty of getting drug treatment when homeless;
- people not being able to cope with being homeless and therefore taking more drugs – which meant they were 'not together enough' to deal with their homelessness (all interviewees referred to this);
- being homeless meant that *'you started mainlining heroin and became addicted.'*

5.7   Other factors which contributed to homelessness

In this section also, a distinction was made between what caused homelessness to begin with and what contributed homelessness being sustained.

5.7.1   Additional 'initial' causes of homelessness

A number of reasons for initial homelessness were cited, including:

- being 'thrown out' because of pregnancy;
- leaving voluntarily because of breakdown in family relationships or violence at home;
- losing tenancy with South Dublin County Council due to rent arrears. Drug use was identified as 'the real reason';
- relationship breaking up;
- house being damaged by fire;
- being evicted for non-payment of rent;
- surrendering tenancy in the context of the Housing Act;
- being barred from hostels (all but one interviewee were evicted from a hostel);
- being evicted from transitional housing;

5.7.2   Additional reasons for homelessness being sustained

The following reasons were provided by interviewees:

- being discharged from prison;
- being in a B&B and having problems with the landlord/lady;

One respondent described sleeping in a shed with her partner and baby and having to leave quickly due to threats from residents that *'they would burn us out.'*

Another respondent referred to the fact that rent allowance does not meet the full cost of rent as landlords/ladies frequently increase the rent so that the rent allowance needs to be 'topped up':

'She wrote down a certain amount but I had to pay more to stay there and I couldn't afford it so I was homeless again.'

5.8   Homelessness – does it cause and sustain drug use?

5.8.1   Homelessness – a cause of drug use?

Interviewees were asked to comment on whether homelessness caused or sustained their drug use. The majority of respondents indicated that it did not. However, it did affect the volume and nature of drug use or resulted in the drug use becoming problematic:

'I started on the drink and tablets in the hostel, what with all the trouble at home and all. I had me first turn on with heroin outside the hostel one morning. The dealers were there offering the gear but I had never injected it. They held my arm and I looked away when they did it.'

While homelessness did not, in the main, lead to the interviewees beginning drug use, several respondents offered anecdotal evidence of situations where homelessness led people into drug use:

'Not for me, but I know people who because of being homeless and having to leave Tallaght and go into town got heavily into drugs.'

'I knew a girl who only used to smoke hash but when she moved into a hostel she started smoking gear because everyone was doing it. The girl she hung out with was scoring gear so she got into it too.'

5.8.2   Homelessness – sustains drug use?

Most respondents indicated that homelessness did contribute to sustaining their drug use. A number of reasons were cited:

- an inability to focus on and deal with the drug problem:
  'Too busy trying to get a roof over your head and trying to block out the homelessness';

- because of *'living in hostels and rough sleeping'* and the associated culture referred to earlier. This is also the case if you have become 'clean', become homeless and have to move back to the homeless circuit where drugs *'are all around you'*;

- it means having to live in town despite the personal drug support network being in Tallaght.

5.8.3   The effects of homelessness on patterns of drug use

As mentioned earlier, interviewees referred to both an increase in drug use and a change in the nature of drug use. People referred to increased use of methadone, heroin, coke and speed:

'My habit got a lot worse since I was sleeping on the streets and I was taking a lot more drugs, because you are trying to block that memory out as well… more phy, more methadone.'

'I used twice as much.'

'I was out of my head all the time. I started doing a lot of benzos because they knock you out and that is what you want.'

Interviewees referred to 'taking anything' to help them sleep or simply to cope:

'I took anything I could get – the cheapest drugs I could lay me hands on – cough bottles, tablets.'

'When you are homeless you are down and low and you want to have something to escape the pain and loneliness.'

Interviewees referred to taking increased risks with their drug use. Examples included *'sharing works'* and using dirty equipment to inject.

Living in B&B accommodation resulted in modified behaviour around drug use. It is perceived as the most desirable form of emergency accommodation and several people described taking their drugs *'off site'* and returning to the B&B to sleep. Respondents also suggested that the experience of B&B accommodation was a motivating factor in bringing about change. This was due to the stability associated with it, the fact there is a low tolerance of drug use in B&B's there are low numbers of drug users being accommodated there.

'You wanted to get your head together and get some help. I didn't want to get kicked out of the B&B because I liked it there and I was using less and less drugs.'

5.8.4   The effects of homelessness on getting help with drug problem

The majority (more than three quarters) of respondents indicated they were unable to get help with their drug problem because of being homeless. They reported difficulties accessing help because of the chaos and the increased drug use as a result of being homeless. Living in hostels or rough sleeping were seen as the biggest obstacle because of the prevalence and availability of drugs in these environments. They suggested that *'when you are on the streets you are not able to get it together'.* Time is taken up with trying to cope with the homelessness, securing accommodation and getting money. The rest of the time interviewees referred to feeling *'so down, you take drugs to get away from the situation'.*

Interviewees reported feeling insecure and not being in a sufficiently settled frame of mind to think about trying to cut their drug habit. Conquering a habit takes determination, support and 'head-space'. Interviewees suggested when you are homeless this is *'out of the question'.* Respondents reported being focused on securing money to score drugs. They described the difficulty of keeping appointments if they managed to look for help in the first place.

> *'I kept thinking I would sort everything else out once I got a place to live. I could not see a way to be settled enough (when homeless) to tackle my drug use. It was just too unsettled.'*

> *'It took up valuable time that I could have spent looking for treatment. Being homeless takes up so much time going from one miserable kip to the next. The only difference is if you are in a clean kip or a dirty kip.'*

> *'All your time when homeless is spent "running around trying to get letters so you can get into B&B and there was no time to get help with your drugs. Being homeless and keeping B&B accommodation takes up all your time.'*

Interviewees referred to the problem of needing an address to access treatment.

> *'You cannot get onto a treatment programme if you are not in their catchment area. You cannot get onto a programme easily if you have no Tallaght address. Trinity Court is the only place you can go and they have a six month waiting list. This is no good when that window opens up inside your head and you need help. You need it there and then or it closes again as quick and that is that. On you go.'*

> *'Me methadone, that's all I want, but it's harder to get on a programme if you're no fixed abode.'*

5.9   The consequences of homelessness on drug use

All interviewees said that one of the consequences of homelessness is that drug use increases and that it is affected by the type of accommodation that people are living in. Rough sleeping and hostels were identified as the least stable, with B&B's, transitional housing and return to the family home being the most stable.

Most of the respondents had already taken some drugs before they became homeless, but all identified a relationship between the stress of being homeless and an escalation in the volume of drug and polydrug use. All respondents referred to a change in the nature of personal drug use. They referred to a transition from smoking cannabis and heroin prior to becoming homeless to heavy use of benzodiazepines, especially associated with rough sleeping. They also said that homelessness resulted in them beginning the practice of taking drugs intravenously, most notably, heroin. People made a distinction between smoking cannabis which most had done prior to becoming homeless and using heroin, cocaine, and benzodiazepines which they identified as 'heavy' drug use. This was a specific distinction made within the context of polydrug use. Smoking cannabis was not seen as problematic, so much so, that it was rarely included in terms of what constituted drug use.

> *'I was using before but when I became homeless it got out of hand. You think you will get drugs just because you are so down and depressed.'*

> *'You get an ok hostel and then you think it's not too bad but then misery and despair set in and when you get the few quid you just get out of it just to get out of the despair for a while.'*

> *'If I had never been homeless I would never have stuck a needle in me arm.'*

'I started injecting in hostels and my habit got larger then. You're mingling all the time, out at night doing drugs.'

Interviewees made definite and unambiguous statements on the relationship between being homeless and increased drug use:

'When you are homeless you are always on the hunt – when you haven't got a roof heroin acts as a mental roof over your head.'

'When you're homeless you will take what you can get and as much as you can get; even if you're 'out of it' you will still take more.'

5.10 The consequences of combined homelessness and drug use

Interviewees identified a wide range of consequences of the combination of being homeless and a drug user. While these are referred to many times in the report, the following section deals solely with this issue.

5.10.1 Health and well-being

Some referred to the consequences in terms of their mental health and well-being. For almost a quarter of the interviewees, this included thoughts of suicide as a means of escape:

'I had me tree picked out and all. I used to think that's where I'll do it, that's where I'll hang myself.'

'I had suicide on the brain.'

'My life was unstable. I didn't care. I just hated life and the only thing that took that horrible feeling away was drugs. I just could escape. I would go home and whatever drugs I would do would just take me away from it. The next day I'd have to go through it again, but when I got something I suppose I just blocked everything.'

'I was back injecting gear and it was very hard and stressful. Most days I wanted to end it and not live this horrible life- just end it and get it over.'

Poor general health and numerous health problems were reported. These included:

- skin conditions;
- being underweight and unfit;
- contracting diseases, for example, Hepatitis B & C;
- panic attacks;
- depression;
- miscarriage;
- baby born ill and needing to detoxify;
- sexual health problems;
- dental problems;
- blood disorders;
- exhaustion due to 'all the walking around the city';
- foot problems;
- pneumonia;
- abscesses;
- gynaecological problems.

'I wasn't eating regular like because of doing the drugs so I was sick, but when you're doing drugs you don't feel hungry so it is like a circle.'

'The worst thing is the mental stress of constant change.'

'I had the fitness levels of a 90-year-old.'

'You get cynical and depressed. Being homeless wipes away your illusions – makes you bitter maybe?'

'When my baby was born she had to go through withdrawal from heroin. It broke my heart. I felt so guilty to see her and know that it was down to me that she was sick.'

There were also psychological consequences, in particular, there was a loss of confidence and self-esteem:

'It will stay with me for the rest of my life. I was so low. Couldn't be worse. Begging and everything. I will never look down on anyone ever again.'

'It can dehumanise you and disillusion you with others so that you lose trust in them. Before I became homeless I could do anything but when I became homeless… it can make you realise that you are here and you are here alone.'

Just under a quarter of the respondents also referred to self-blame as a cause of distress.

Loss of contact with and respect from family caused a lot of distress. Respondents were acutely aware of the pressures their families were under because of their behaviour.

5.10.2 Loss of support networks and opportunities

Interviewees referred to losing support networks and friends who are not homeless and/or do not take drugs:

'Devastation. Transient. Displaced. Man on the moon again only this time it's the dark side of the moon.'

They also spoke of lost opportunities in terms of getting onto educational courses, getting involved in sport, a job and 'living a normal life' in general. This was attributed to addiction:

'I threw it all away for fuckin' drugs yeah.'

5.10.3 Lack of money

Lack of money (because it was needed to score drugs) was reported by all the respondents as a major issue. There was recognition that the money spent on drugs could pay for a deposit on a private flat:

'You have to take care of your addiction first, so if you have money you get the gear first and the food second, and if there is not enough for food then you have no food.'

5.10.4 Discrimination

The understanding of discrimination as used here refers to the fact of being a drug user resulting in the unjustified denial of a quality service one would otherwise be entitled to. Almost all interviewees believed that they had been discriminated against as a consequence of being an out-of-home drug user. Examples included; being placed in poor accommodation, being subjected to personal and room searches and generally treated with suspicion and hostility.

5.10.5 Additional consequences

Other consequences were also identified. These include:

- Getting involved in criminal behaviour (robbing, begging and prostitution);
- Developing cross-addictions;
- Getting beaten up, robbed, sustaining long-term injuries;
- Losing children to care;

'If I'd never have been using drugs I'd be having a great time. I'd have me kids back and I'd be going on holidays – I'd be living a normal life really.'

5.11 Experiences of homeless services – general

Interviewees were asked to comment on their experiences of homelessness services. Experiences varied between agencies and individuals. There were a number of common themes.

5.11.1 Differential treatment

Consistently, interviewees suggested that not being looked upon as a person, 'not seeing you as a human' was the biggest obstacle they experienced when trying to access homeless services. Where this fundamental respect was perceived to be lacking, respondents felt that they had 'no chance' of being afforded any opportunity to improve their circumstances. Not being listened to and being judged straight away, were two experiences, which were cited frequently as causes of frustration and feelings of injustice:

> 'I suppose if they would just give you a chance to explain and just listen to what you have to say instead of judging you straight away.'

> 'The attitude was 'it's not my problem'. Once they see the word addict appear, you are labelled.'

> 'They look at you if you are on drugs and they say to themselves 'this fella doesn't give a rats about himself so why should we?' I suppose they don't see it's worth it.'

> 'They look down their noses at you. They think that if they refer us to a nice place we will bring people in and wreck the place.'

> 'If you are not on drugs you are great you are wonderful.'

> 'They want to get you in and out as soon as possible – you're only an 'oul junkie'.'

> 'They exclude you and treat you with no respect once they know you are on a programme (experience of a refuge).'

> 'They were hostile to me – they were not interested in helping me.'

> 'These people just didn't understand. They were coming at it in a silver spoon style.'

All the respondents felt certain they were judged by their appearance upon presenting at homeless services. They said that staff were able to see they were drug users straight away by looking at them and that this affected how they were treated:

> 'They can spot you like a shot – these people are experienced and they know if a person is just looking for money or is genuine. Trouble is we all get tarred with the same brush as the junkies who are not genuine and so when these staff see junkies they are unsympathetic.'

Individual staff members were perceived as discourteous and unaware of the realities facing those with a drugs problem. There was also widespread recognition of the pressures that faced staff working in these services:

> 'I am a very quiet person and I have a lot of respect for the people working in these agencies and wouldn't want to shout. But then I think they thought I was stupid – so it was like being loud you would have a reputation – but being quiet they thought I was someone they could stand all over. You were in a no-win situation.'

Being able to disclose being a drug user is a pre-requisite to getting help and support. Most of the respondents did not feel that this was a good idea because of subsequent levels of discrimination they would experience:

> 'With some agencies yes – definitely Merchants Quay and definitely not the SDCC. Focus Point yes, but not the social welfare officer because when you go to collect your money, you just feel judged and looked down on, they are thinking we're gonna give this girl money now and she's just going to go out and buy drugs... if you were looking for money for something that you needed genuinely, you maybe wouldn't get it.'

5.11.2 Rights and entitlements

Interviewees were asked to comment on whether they had been informed of their rights and entitlements:

> *'Social workers talk to you about it but it is all big words.'*

> *'Well they'd be all blah blah blah but your time was up and you didn't hear it – they just wanted you out – not talking to you just talking at you'* (referring to point of eviction from B&B).

> *'Today coming here (THAU) I found out I had rights I didn't know about to do with the council.'*

> *'At Merchants Quay we started looking into it but never at Focus Point.'*

Given that many had negative experiences of service provision, interviewees were asked whether or not they had issued formal complaints to any of the agencies. All said they had reason to complain but few had actually done so. Those who did felt they were not listened to. Also, while some interviewees were aware of their entitlement to complain, they had a sense of not deserving the same quality of service as non-drug users. For some there were the added practical considerations of not knowing how to complain or low awareness of rights of appeal (for example, on eviction from accommodation).

> *'I just got to the stage where I didn't care. I was getting to the stage that being on the street I said we'll die on the street 'cos of our livers and all. We lost the children and nobody was doing anything to support us – all they were doing was asking questions but we weren't getting nowhere.'*

> *'What would be the point? I am only a number to them.'*

> *'I didn't feel I had enough power and that I would be listened to.'*

> *'It would have made no difference. They are in charge and you are only a junkie.'*

Fear was also an inhibiting factor when it came to making a complaint or asserting the right to a service on an equal footing with others. Interviewees were afraid to complain in case the landlord evicted them or labelled them as a troublemaker; in which case it was felt no-one would help them:

> *'I did not know how to or that I could. I did not know my rights and was afraid that I would be blacklisted if I complained and then I would never get a place of my own.'*

> *'Who would I complain to? No-one is interested and it wouldn't get me anywhere anyway.'*

> *'There would be no point and then they would have you pegged for a troublemaker and you would get nowhere.'*

> *'Maybe I am just bad at standing up for myself.'*

> *'I would be afraid of losing the home I have now or before I would have been afraid of not getting a home.'*

Interviewees identified a change in the way in which services are responsive to out-of-home drug users. Descriptions of treatment in the early 1990s was contrasted with current experience. Broadly speaking, services were felt to be improving, but not significantly. Much appears to be dependent on individuals who work within each service.

5.12 Agency-specific feedback

Participants in the research tended to present information on their experiences of services on an agency-by-agency basis. In order to ensure that feedback is attributed to the agency to which it refers, this information is therefore presented on an agency-by-agency basis. There was a general consensus that while people had negative experiences, interviewees also had positive experiences usually attributed to individual staff members. In the main, criticisms were directed at statutory rather than voluntary or community agencies.

One of the key challenges in presenting feedback from the interviewees in relation to particular services is the need to protect the confidentiality agreement made with interviewees (both users and providers) while at the same time needing to protect the integrity of the report by reporting on feedback.

The following section presents feedback from the interviewees on the Homeless Persons Unit.

5.12 Homeless persons unit

- There were differing opinions on its role in helping to find accommodation – some described the approach as helpful, others as unhelpful;
- There was no emotional or other form of support provided;
- Support for/with children was not given;
- Interviewees felt that they were not listened to or respected; were treated poorly and/or in a discriminatory manner; were not made aware of their rights and entitlements;
- In three cases, families were accommodated separately;
- Some interviewees referred to being placed in poorer accommodation because of being perceived/known as a drug user;
- More than one third of the interviewees reported that the service received depends on *'how you look'*;
- Others reported that the service received depends on the person delivering it;
- All interviewees indicated that there is little or no understanding of the needs of drug users demonstrated;
- Being treated well was rarely reported; *'She was like a bright star in a black sky shining out'.*

Comments from interviewees include:

'My first time in Charles St.,[27] I couldn't believe such a place existed. It was Dickensian, mainly dealing with middle-aged men who were alcoholic.'

'If you are using drugs or on methadone, they take the other people in front of you so the best places go to them.'

'You are unclean because you have no way to wash and it affects how you are seen.'

'A person without a habit does not have to spend his money on drugs so he can have a better appearance and he gets treated with more respect.'

'There are some good people out there who care and want to help – they are dedicated and it matters to them what happens to you.'

'They are suspicious of you and don't put themselves out for you because they think all junkies are the same and are a waste of their time.'

'Some are and some aren't. Some could leave you waiting in line for two hours. Others go out of their way to help you.'

'You're seen as trouble and not worth taking the trouble for. If you are on drugs they sling you all into Haven House-all the junkies together. People on drugs are not all the same and deserve a chance like anyone else. Some don't want to change-they are not interested, but others do.'

'They don't care, they just book you in. They say you are on a list and you might get a house in four or five years. They don't help you to find accommodation, just shelter.'

Interviewees spoke of the obstacles which had to be overcome in order to get booked into accommodation when there was an accusation of Anti-Social Behaviour, whether founded/proven or not. That an individual (and perhaps a family) could lose the right to be accommodated was experienced as a deep injustice. There were consequences for family life and relationships. It was also identified as a cause of distress and mental and emotional suffering. Because the client group is vulnerable to addiction this pressure can result in a disruption of stability thereby enhancing the risk of increased drug-taking.

The following case study illustrates some of these points

27 Even though there are now two offices providing the service previously delivered at Charles St, for the purposes of this report, we understand references to 'Charles St.' to be generic and in relation to the service as opposed to one particular office.

Case Study 1:

Separation of family due to allegation of Anti-Social Behaviour by private landlord

A family living in private rented accommodation was evicted for having one month's rent arrears and allegedly for drug dealing. They presented at HPU and the mother and child were told they would be accommodated but the father would not. The reason given was Anti-Social Behaviour (drug dealing), which HPU staff said would put other families at risk. The man was refused rent allowance. The family slept in a car for ten nights and presented at HPU again. They were booked into accommodation for three nights, at the end of which they were told the woman and children would be accommodated but the man would not. The man was asked if he had ever been raided or convicted of a drugs offence, to which he said 'no' as this was the case. The HPU staff said that the landlord said he was drug dealing and she believed the landlord. He had been checked out with the Garda and SDCC Estates Management, and he would not be accommodated. This meant he was classed as No Fixed Abode (NFA). Being of No Fixed Abode he could not get on to the housing list as SDCC said they could not accommodate him and he would have to go to the HPU, who refused to accommodate him together with his family. He went to the homeless officer at SDCC in Clondalkin who said she could not help him as he was of No Fixed Abode. She said she could take his name but that was all she could do. He could not register as homeless because he was homeless. He had problems getting onto a treatment programme because of being of No Fixed Abode also.

The family continues to live apart. They feel they are being discriminated against because they are denied their status as a family on the word of a landlord, despite no proof, and no real substance to the allegations.

5.12.2 Hostels

As stated earlier, hostels are perceived as high-risk accommodation provision because of the drug culture which predominates. In addition to problems with the nature of hostels, some issues were identified in relation to the service:

- some interviewees referred to being unfairly evicted;
- some reference was made to problems in accessing hostels which do not admit active drug users;
- 'dealing' in the hostels was reported by almost a quarter of respondents;
- one interviewee referred to the difficulty presented by restrictions. She cited the example of children having to be in bed at set times.

'I suppose in ways they'd rather not have you there and if they could think of reasons to get you out they would – like sleeping on the end of a girl's bed – that would be used to bar us.' (This interviewee had been barred for sleeping at the end of another girl's bed).

5.12.3 SDCC

The following section outlines feedback from interviewees on the SDCC and relates to the homeless service and estates management.

Experiences under the 1997 Housing Act are addressed later on in the report. Interviewees referred to:

- not being treated fairly. Fair treatment was defined as being able to get housed via a fair, open and transparent allocations system. Single men felt particularly hard done by;
- being taken off the housing list with no way of knowing it had happened, and therefore not being able to do anything about it;
- not being helped with accommodation, but just sent to the HPU in town;
- being treated discourteously (not related to current staff);
- poor service in terms of repair and upkeep of accommodation;
- Estates Management team was viewed as *'not caring whether a person was made homeless'*;
- staff not accepting a person as homeless because of being of 'no fixed abode';

- not being fully informed of how the system worked (for instance, one interviewee had not been told by SDCC that he had to keep checking in with them when he was homeless or he would be taken off the register. If he had known, this would clearly have made a difference – he would not have thought he was on the list when he had been taken off);
- errors being made by Council staff (for example, one interviewee referred to a situation where she registered as homeless and was sent to the HPU in town. She kept in touch with SDCC and found out that her name had been taken off the register. She was registered in error by the SDCC as living at her mothers address. She was told 'sorry, but we can't rectify that mistake'.

'The attitude was 'it's not my problem. Once they see the word addict appear you are labelled.'

'The council were no help to me it's the other people I got to know at Wellington Quay who are homeless and they tell you where to go when we're waiting to be seen.'

'We got sent to Clondalkin from Tallaght and told we are gonna be on a waiting list for 4 or 5 years. I says sure we're 4$^1/_2$ years waiting as a couple so how long more? But we still haven't heard anything.'

Case Study 2:

Eviction of a squatter by SDCC

A woman was staying in her friend's house (the friend in whose name the tenancy was no longer stayed there). She had been living there for a year with her children when SDCC Estates Management Officers came to the house to say she had no right to stay there – she was not the tenant and the tenant had vacated the property. She was told that if she handed in her keys and got her name on the housing list she would be rehoused within three months. If she waited to be evicted as a squatter she would find it hard to get help as they would be evicting her under the Anti-Social Behaviour section of the 1997 Housing Act – due to the behaviour of a family member. She was afraid not to give in the keys; 'in case it would blemish me and they would not help me to get the house – I was afraid I would be blacklisted'.

She gave in the keys and went to see the Homeless Officer at SDCC who said 'there is nothing we can do for you. You have to go into town to get a place to stay'. She was very upset and had her children with her. As she left the SDCC office, a passer by said she was appaled at the way in which she had been spoken to and their lack of compassion at her obvious distress.

At this time she had a baby and was pregnant with the second child-she was afraid to go to town. She stayed with her sister for 3 months until this arrangement broke down.

5.12.4 B&B accommodation

Feedback from interviewees on B&B accommodation referred to the following:

- that there was no privacy due to room checks being carried out by staff. Respondents had experiences of both being asked to leave and being challenged as a result of evidence found in their belongings when they were not present. In some cases needles were found and in another, an appointment card for a drugs clinic. This experience reinforced interviewees' beliefs that if people knew you were a drug user you would be discriminated against.
- that this is the best accommodation available for homeless people but *'you won't get in if you are a drug user'*
- being kept for the first night (with children) and being subsequently told they don't take children. Interviewees said that the sudden change in policy was because even though the day before they said they did, and knowing it was because *'they knew you were a drug user'.*
- being evicted for drug use without proof.

Comments from interviewees in relation to B&B accommodation include:

'They find out that people are drug users by room searches. If you were an addict you could not be open about it as they would not accept you. If you were an active user you would not get in.'

'I would hide it. I would lie. Well, you would have to; you wouldn't have a chance would you? Let's call a spade a spade here. Would you let a junkie in?'

5.13 Most useful services and support

In order to glean a sense of what is working effectively within the system, interviewees were invited to comment on what they found to be most useful in terms of the services they have experienced. Some interviewees named issues and some named specific agencies:

- being treated with respect and listened to (identified by all respondents)
- being helped to find accommodation which did not 'split up' the family
- being treated with dignity; *'when people get to know you and see you as a person and not just a homeless drug user'*
- being awarded disability allowance
- getting into a B&B (named by several interviewees)
- Merchants Quay for help and a clear understanding of what it is like to be an out-of-home drug user
- THAU for giving support and accompanying people to get flats, appointments with Council, emotional support and respect, sleeping bags, tents, cups of tea, somewhere to go, and making phone calls (named by several interviewees).

5.14 Least useful services and support

With the purpose of seeing where services could be improved, interviewees were also asked to identify what they found to be the least useful or effective aspect of the services they had encountered. Below are listed a selection of the issues raised:

- Charles St was mentioned by anyone who particularly had contact with the its Homeless Persons Unit. Interviewees highlighted the frustration they experienced as a result of making efforts to get out of the system but feeling blocked by the system. For example, one interviewee had found a flat and the HPU indicated they would pay the deposit of £500. However, because he wanted to take the tenancy out with two other people, both of whom were working, the HPU would not pay the deposit. This was despite the fact that he had only requested his own share. He lost the opportunity to get out of the emergency accommodation system. He also felt he lost an opportunity to develop a life with new friends who did not use drugs. Effectively, he felt, the homeless service kept him homeless;
- interviewees referred to the HPU 'making you run around getting letters from doctors' to get into a B&B. This was regarded as particularly stressful for a respondent who was unable to read and write. Every month, he had to prove his need and status were still the same in order to retain the B&B accommodation;
- being sent from one place to another and 'getting nowhere';
- the HPU 'asking too many questions' and 'shouting at you' or 'turning you away';
- not being provided with sufficient information on entitlements;
- the nature of accommodation, resulting in separation as a couple and as a family;
- being informed by the local authority they would have to go on a list for four to five years to be housed;
- several interviewees referred to agency lack of understanding of the issues facing out-of-home drug users and linked this to feeling they could not be open about being a drug user for fear of loss of accommodation;
- being evicted by the local authority;
- being informed by the local authority Estates Management section that 'she would be rehoused' and then being offered no help;
- private rental agencies *'looking at me like I had no chance.'*

5.15 Solutions

Interviewees were asked to identify suggestions and solutions, which they felt, would enhance the quality of service they received or help bring about a change in their situation. It was striking, when respondents were invited to consider an ideal service which would meet their needs, upon first consideration, expectations were very low. They were confined mainly to; having somewhere to sleep, food, a place to wash, and someone to talk to, who could listen and help. Several of the

respondents thought that a place where they could get sleeping bags and tents, wash, eat, make phone calls and 'store their stuff' during the day was the ideal and probably the best they could hope for. These were seen as the essentials.

'I am lucky because I have a good sleeping bag.'

'Just somewhere to wash and shave, get food and sleep in out of the weather so you could feel a bit human again. I know locals would object but if it was really well run it would make such a difference.'

The majority of respondents identified a need for Tallaght based solutions – in particular, the need for accommodation in Tallaght. Here, reference was made to a safe space, a place where belongings could be stored and most importantly they referred to the opportunity to live in a place which was away from the hostel drug scene. Interviewees also indicated that homelessness and drug use should be addressed 'under the one roof':

'The place would be big with its own cooking facilities showers and that. People on a programme would be let in. There would be a place for active users where people would be able to understand addiction; counsellors would be there for people and access to immediate treatment there and then. This is important because you need three clean urines to get accepted on a programme and you will never have a clean urine when you are on the streets.'

'There is nothing for the locals. The priest at the Priory used to help us. If there was a small hostel in Tallaght for people sleeping out it would really help.'

'People would not be allowed to hang round outside preying on the residents.'

'Give them somewhere to go in Tallaght and break the circle in Tallaght – there's no good just giving people a bed and then kicking them out – that's just a circle.'

'Help and a chance of hope. Giving some sort of a place for the homeless in Tallaght instead of having to go into town.'

'A place in Tallaght which had crèche, acupuncture, reiki, somewhere to eat and make phone calls, a counsellor and keyworker.'

All interviewees spoke of the need for supportive staff who listened and treated the client with respect and dignity. They referred to the importance of having staff who understood the situation:

'Someone that could tell you that you would have a chance if you went to see so-and-so or do such-and-such. Someone who could give you information and tell you where to go. I can't do that for myself 'cos I keep getting caught in a circle. I am in with a crowd and I can't get away from them and they are throwing drugs at you all the time.'

'They should be treated the same as anybody else and given a chance.'

'They don't realise how bad it is or what it is like. We are people. You've got nowhere to go, you've got nothing.'

The need for people who have personal experience of homelessness and drug use to be involved on committees and in the development of solutions and responses was identified. It was also suggested that ex-addicts should be working as counsellors in the drugs services because they

'understand where people are coming from – they have been there.'

'Younger people on committees and representation from the people who know what it is really like out there.'

'Those who have been through the experience are the best ones to talk to because they know what is what.'

A variation on this was an identification of the need for an advocacy service as it was suggested that:

'homeless people who are drug users are not able to represent themselves due to their condition, and do not get listened to, once it is known they are a drug user. People in addiction cannot represent themselves, therefore they cannot access the services which can help them ease their situation.'

Reference was made to the need for follow on support when the homelessness and drug use is being addressed and crucially for a facility which could immediately respond 'on the spot':

'You need to talk to people and ask them what they would like to do that day. Immediately. Stop them from drinking and drugs and have something for them to do. A course or something. A roof over your head is not the end of it.'

Most of the respondents spoke of a need to change the way in which the housing list system operates within SDCC. They suggested that when someone is homeless, their application should stay 'live' unless they s/he contacts the SDCC to inform them of a change of circumstances. This would end the current situation in which people get taken off the list because they do not reply to a letter which they did not receive. Essentially the suggestion is that the onus should be on the service provider to provide the service and not on the homeless person to continually prove their need.

Interviewees also referred to additional practical changes which could be made within the system:

- all respondents referred to the need to be 'listened to' at the local authority and HPU
- the provision of rent in advance for private rented accommodation as a alternative to the current system which one interviewee described as *'making and keeping people homeless'*
- respondents referred to a need to *'clean up the dealers in the emergency accommodation system'*
- an increase in the range of accommodation options available (reference was made for a need to accommodate young girls) and an increase in the volume of B&B accommodation
- the local authority should provide help to people who are No Fixed Abode
- a change in the way in which Anti-Social Behaviour is addressed by SDCC
- accommodation options should not result in families being broken up
- the creation of an extensive support and aftercare programme for drug users who have been through rehabilitation to help them in their own community; *'the likes of Cuan Dara are great but it only works while you are there'*
- increased staffing resources within existing services.

5.16 Experience of drugs services

The respondents overall had little criticism of drugs services, other than the catchment issue already mentioned and the high turnover of counselling staff. It was felt that help and understanding had been given, this was specific to drug use and not homelessness, other than referring people to THAU and writing letters to accommodation providers.

Interviewees referred to a need for GP's to listen to long time addicts because they have a thorough understanding of addiction and *'doctors don't know what it is like to be addicted'.*

'I say that they know fuck all about habits – they want to go and get strung out and then try to come off it. Then they'll know what its like – they'll understand and they'll have a bigger horizon about how bad drugs really are… they don't want people over 30 they just want the ones in their early 20's that they can manipulate, which is wrong, whereas if they came to us and just listened they would find out more'

'Having more staff and really listening to people that really know what it is like. There needs to be more methadone and phy for people on programmes. The doctor tells me what I get will hold me for 72 hours but 90 mls I get is not enough to hold me. Within half an hour of taking 20mls of phy I am sniffling like a dog'

Some suggested that some people access maintenance programmes *'just to make money',* interviewees referred to the large scale sale of methadone (phy) on the streets.

'The ones they see are not even in need of maintenance and I know that because I buy that phy off them when they get their take-aways and that is how I come on me phy for the day. They're just in it for the money and probably keep 10 or 20 mls a night for themselves, so it will show up in their urine when they go back to the doctor. They are making money on it.

Interviewees also referred to the turnover of drugs counsellors as being a barrier to getting support:

'They all leave just when you are learning to trust them and you have to start and tell it all over again and just when you trust them and believe it will work they are gone and then you are on your own again'

Reference was made to the fact that people providing drug treatment services are faced with limitations:

'My own self-motivation was the most important thing – no-one can help you without that.'

5.17 Evidence of an integrated approach

Given the increasing emphasis in recent years on inter-agency and integrated responses to social exclusion, interviewees were asked to comment on whether their experience of services provided any evidence of this integrated approach.

Only two of the research participants said they felt there was contact in any structured way between drugs services and homeless services. There was surprise that the two issues should be perceived as needing to be linked in terms of service delivery. Respondents felt that in order to become drug free the individual had to be well motivated. This was the point at which drugs services were needed for support.

When people are actively using, interviewees felt that homeless agencies should provide them with treatment and holding facilities until they were able to move on, or they should recognise that there are some people who would always need supported accommodation. A number of respondents were of the opinion that active users who are unable to help themselves should not be given help that could be used better by others, who are at a different stage of coping.

Assistance with homelessness was not perceived as being the responsibility of drug services:

'Drugs places just deal with the drugs for you, they just want to see you getting clean'

'They cannot help you with your homelessness because they are there to deal with your habit – and when you are homeless you can't be helped by them – so when you get to them you are more stable anyway'

One respondent referred to the futility of an integrated approach:

'They are all looking for the same money. Even the needle exchanges are fighting. How can they work together when they are all under-funded and fighting for the same money?'

5.18 The 1997 Housing (Miscellaneous Provisions) Act in practice

Of the seventeen interviewees, two were the subjects of exclusion orders under the above Act. Two were 'under threat' of one (one being a tenancy holder and one being the partner of a tenancy holder), one of whom referred to being monitored by the local authority. Most of the interviewees had never got as far as having a tenancy due to the chaotic life they were living.

Other experiences relating to the Act include:

- only one interviewee is currently in a tenancy without any trouble which is linked to being known as a drug user;
- one interviewee had voluntarily surrendered accommodation because of a fear of being evicted under Anti-Social Behaviour;
- one was 'hiding drug use' because of a fear of Anti-Social Behaviour (referred to the high level of anxiety this caused);
- one had been told that the tenancy was lost due to rent arrears, but the client believes it to be drugs-related;
- one interviewee is currently beginning the process of getting rehoused after two years;
- one lost tenancy due to Anti-Social Behaviour – the interviewee left when neighbours threatened to burn the house (SDCC staff were present during this incident).

Of the seventeen interviewed, five have had a tenancy – four of whom are women.

Some of the issues, which have emerged for service users in the implementation of the Housing Act, are outlined below. Incidences were cited at length in the course of interviews. To give a sense of the experiences of the interviewees, case studies are provided to illustrate the issues raised (see below).

5.18.1 Consequences of Eviction

The consequences for the individual of being evicted under Anti-Social Behaviour are that a person can be refused:

- rent allowance to assist with moving into the private rented sector;
- accommodation in emergency hostels and B&B's;
- re-housing with any social housing provider who has the right to run a check on a prospective tenant and refuse them accommodation because they have been evicted for Anti-Social Behaviour.

This situation effectively takes a person or family into a space where they have no right to housing and homeless services.

Of the five people interviewed who had a tenancy with a local authority, two were the subject of indirect activity under the 1997 Housing Act. As a result, they entered the world of homelessness and temporary accommodation, that is, they left their tenancies voluntarily under threat of eviction for Anti-Social Behaviour. When the Act is used indirectly, it appears to be most potent. A tenant is told s/he will be evicted under Anti-Social Behaviour for non-compliance with the wishes of the local authority – this could be to modify behaviour or to remove a family member from the tenancy. At this stage, in effect, a tenant has three options. S/he can hold onto the tenancy and avoid becoming homeless by co-operating with the eviction of a family member. Alternatively, s/he can choose not to comply with the local authority and be evicted under Anti-Social Behaviour or s/he can voluntarily surrender the keys. The latter means that even though the tenant is now homeless options have not been eliminated because of an Anti-Social Behaviour label. Feedback from the research interviews suggests that at this stage, the tenant understands that eviction is inevitable and s/he selects the option which gives breathing space – voluntary submission of tenancy.

Other issues raised by interviewees include:

- seeking to be re-housed by the local authority is very difficult;
- those who wanted a tenancy would have difficulty in getting one. Participants spoke of not being contactable because they are moving around in the emergency accommodation system (this is especially the case if family relationships have broken down). This means that they are 'lost' to the process of being rehoused by the local authority, as the system it operates is dependent on regular contact and letters being (sent to the address given when being placed on the register) being acknowledged. Some think that because they put themselves on the homeless register they are on a housing list (this is not the case);
- being asked to leave because of Anti-Social Behaviour means a person or family ends up being homeless again – in a number of instances this involved sleeping rough locally in sheds in Tallaght. Consequently, drug use escalated and polydrug use would be common at these times;
- the process of eviction is unclear to tenants whose lives are unstable as a result of drug use. Keeping appointments, remembering what was said at meetings or remembering what stage a process is at are all difficult for people experiencing the chaotic lifestyles associated with problematic drug use;
- interventions by local authority estates management staff are experienced as yet another problem for people who are struggling against the odds to keep their lives together. The lack of support offered means interviewees experiences the process as one of exclusion rather than positive intervention;
- the role of residents committees as those 'on the ground' in estates was identified as important. If members of these committees see that a person is a drug user, they fear that this in turn will attract more drug users which will bring dealers into their area. Consequently, they want to get rid of what they see as the potential starting point of the problem – the drug use. Levels of fear around this were understood by the respondents to the research, but their experience was that the distinction was not made between being a drug user and being a drug dealer. The consequences are so serious that it leads to high anxiety and fear of disclosure on the part of drug users – this was linked to escalated drug use;

- issues were also raised about the relationship of people on residents committees to the drug users and/or their families and its effect on how they are perceived, and consequently treated.

Case Study 3

This interviewee described how he had to sign a consent form for all his records to be checked before he could even be considered for a tenancy. He had to have six months' of clean urines and letters from his GP; 'I got the impression that there was no way the individual officer wanted a junkie on their patch'.

He finally got offered a flat at 12 noon on the day in question. Because he did not have a clean urine for that day the offer was withdrawn at 3pm. He said he would go to the clinic and get one but he was told to "drop it till next week- the flat is going to someone else now anyway". He asked to speak to a Senior Allocations Officer but in fact was spoken to by the Estates Management Officer, who he felt was not interested in helping him. He contacted a Garda who advocated on his behalf with SDCC and he had a flat within 24 hours. He felt that on his own accord he had no rights, was not being listened to or treated fairly and was unable to effect change. Without the support of the advocate, he believed he would have lost this opportunity.

Case Study 4

The tenant in question was living as a tenant in a SDCC house with her children. She left to look after her mother who was ill, but her friend stayed in the house. She visited regularly but her friend did not pay the rent and there was £500 arrears owing. SDCC evicted her for non-payment of rent but she felt it was really to do with Anti-Social Behaviour because neighbours told her that there were rumours of dealing from her house.

She had a large habit and was focused on maintaining her habit while being with her mother who was ill, therefore she did not argue with the SDCC but 'just gave in'. She feels that she was in such a state 'she could not take in what was going on or worry about it'. She has been waiting 5 years to be rehoused, and has been told by SDCC that she will have to prove to them that she is able to cope with a tenancy before she is rehoused. She does not understand how she is required to do this as she has been given no further information.

5.19 Concluding comment

One of the most striking conclusions from this section of the report is the complex, interweaving and chaotic nature of the issues which emerged. It proved impossible to deal with any one issue in isolation. Each problem, both in nature and potential solution was affected by a complex set of factors. This was mirrored during the interview process as conversations meandered and moved fluidly from one issue to another. This is reflected in the apparent overlap of information when in fact there are subtle differences and distinctions. A clear, yet complex picture emerged. Key issues arising from this information and also that arising from service provider interviews are presented in Chapter 6.

Chapter 6 – Interviews with Service Providers – Findings

6.1   Introduction

As outlined in the methodology section, thirteen semi-structures interviews were held with representatives of a range of agencies – statutory, community and voluntary. Interviewees included; community welfare officers, staff working with drug treatment services, personnel from the Housing Unit, personnel from the social inclusion unit within the Health Board, a voluntary organisation working in the area of drug use, a manager of health board approved B&B accommodation, an owner of a private commercial B&B, an emergency hostel worker and other personnel within the Health Board and SDCC.

Given that the scope of the research includes both policy development and the nature and quality of service delivery, interviewees included both policy makers and front line staff. Interviews explored a range of topics including;

- nature and extent of contact with homeless drug users;
- individual perceptions of homeless drug users;
- experience of the service being delivered;
- organisational policies, procedures and practices;
- training available within the organisation;
- relevant legislation;
- feedback/complaints system;
- challenges to the service;
- individual perceptions on the links between homelessness and drug use.

In the course of the interviews, key themes emerged which highlight the complexity of issues which contribute to the effectiveness with which those responsible for service delivery can meet the needs of homeless drug users. These themes are addressed in addition to the topics outlined above.

Throughout this section, some quotes are attributed to individuals and some to agencies. When only one individual within an agency was interviewed, this is generally interpreted as the agency perspective. However, in for example the case of the local authority, as more than one individual was interviewed; the perspective is presented as an individual one, as frequently there was a variety of perspectives.

6.2   Ways in which agencies ascertain whether or not a client is a drug user

Given that the purpose of the interviews was to glean feedback on the experience of homeless drug users as a distinct category of client one question focused on how staff became aware that their clients are drug users. There were a wide variety of responses.

One local authority employee pointed out that this information would be elicited from a client at interview stage. The information, it was suggested, would emerge in the context of a discussion on previous tenancies which could include information on previous evictions. While this information would initially be disclosed or revealed during initial interview it was also likely to be substantiated during subsequent contact with agencies.

Another local authority interviewee said she always asks people if they are on a programme but doesn't understand why she has been told to ask this.

Reference was made to information becoming known because of local knowledge (family members contacting the agency) and informal networks:

> 'I'm a long time in the area and I know the families, people know me. So, I would know even though they wouldn't tell. The family members would tell. For instance if I sent money to the one who asked it to be sent – it could be spent on drugs – so someone in the family would tell me. There's also informal interaction between agencies – we would

know each other. Some stick to the rules and regulations, I'm one who believes they can be bent to assist the individual. They're not there to be strictly adhered to.'

A Health Board employee, whose service has a role in placing people in emergency accommodation referred to the fact that this information is critical in terms of effective implementation of their service.

'We'd have to be aware (because of the placement responsibility) – the assessment would tell us. A high percentage of our clients would be users. We would have residential contact. We would also be in contact with the treatment centres, private GP's etc. We wouldn't just rely on the evidence of the client.'

Reference was made to the fact that this information is taken into account in terms of placing people in accommodation:

'We book people into a B&B or other hostels – we try to keep them away from other users. There's high pressure. There's very little downstream accommodation for people who are trying to detox.'

Another interviewee referred to physical appearance and disclosure by the client.

'Pitch of voice, appearance, behaviour. A lot of the time – they would tell. Some looking for B&B accommodation – we would have to find out if they're using – they would be honest, they'd want to talk to you. They'd say, I'm short of money – I'm using heavily. The majority would generally be open and honest about it. If they're in the hostels, it's rampant there anyway – there's no point in not being open.'

Another interviewee who is responsible for the provision of accommodation refers to operating a 'need-to-know-based policy', adding: *'some people tell you, some don't'.*

6.3   Homeless drug users experience of services – different to other service users?

A second question that arose was whether interviewees thought that homeless people who are drug users were treated any differently from other service users, including other homeless service users. There was a wide variety of responses to this question. Some referred to the quality of the service while others commented on the *nature* of it.

6.3.1   Anti-social behaviour (ASB)

In the context of the *nature* of the services received by clients, the issue of Anti-Social Behaviour was raised. In so doing, there was a distinction drawn between the service received by drug users and drug *dealers*.

An employee with a local authority acknowledged that this is an issue and from the authority's perspective referred to the possibility of Anti-Social Behaviour and its effects on the rest of the community. He referred to the procedure whereby residents committees are informed of prospective tenants prior to letting and *'if there was a problem,'* committees would inform the local authority. The local authority subsequently investigates the case and if there is a conviction for drugs related offences, the tenancy may be refused. The interviewee was clear that *allegations* made by residents committees in themselves are insufficient – proof of a conviction is the deciding factor. There is a distinction drawn between users and dealers and an acknowledgement that:

'A high percentage of people on our waiting lists would be users – if we were to treat users in the same way as dealers, we would end up housing nobody.'

The nature of a drugs conviction is also considered, the quantity of the drugs offence rather than the type of drug, is the key issue which is taken into account.

The basis on which the information is assessed and how it would affect the client was described as follows:

'Well it would depend on how serious the problem is. It would be up to the Allocations   Support Section. Based on their recommendation then I would either proceed with an application or not, defer it, put it on hold… basically until the Allocations Support Section are satisfied that it's ok to proceed with the application.'

Another local authority interviewee would 'not say yes or no' in response to the question whether or not problem drug users experience their service differently. He added there was anecdotal evidence to suggest that this group don't access (the local authority) services at all as they perceive that there is no point (wrongly in his opinion). In cases of anti-social behaviour, he stressed that the Council targets pushers not users. They *'have a responsibility to the entire community and have to consider all sides'.*

6.3.2   No distinction

Others stated that there is no distinction made in the delivery of services to homeless drug users. A number of respondents commented that 'it goes with the territory'. It is expected that if you are working with people who are homeless invariably there will be active problem drug users. Conversely, those employed in services working with drug addiction expect that some clients will also be homeless:

'I would say for example the vast majority of substance abusers are homeless. It's kind of expected that people would be substance users.'

'It goes with the territory. You get immune to the fact – it's part of the situation. It wouldn't have any bearing on the payment we give them, for instance. There's a high level of empathy among staff here. There's a good understanding of people's needs and wants. Staff know where people are coming from.'

'We certainly wouldn't have a policy of treating people in a different way. We refer users to treatment centres – there wouldn't be a prejudice.'

'It is important to treat them the same as anyone else and try to get a sense of responsibility into them for their actions.'

'There's no distinction, if people are vulnerable because of drug use, we would place them in a B&B. However, if people are actually using – we can't place them in a B&B where there's women and children – there may be no supervision. We would have a chat with the client – we would explain why we can't place them in a B&B and we would offer a de-tox programme. They would usually be okay about it – often they would say they're happy using at the moment.'

Others referred to positive discrimination:

'No, they're treated exactly the same, although I suppose in some ways, I would go more out of my way to help them.'

'I have a woman staying with me at the moment who is also a drug user. (I'm happy with that) I feel sorry for her. I understand what addiction and depression are like (referred to suffering from depression and being on valium). When people stay, they can come in during the day for a cup of tea...'

6.3.3   Where differential treatment does exist

There was also an acknowledgement that differential treatment does exist.

'There are prejudices within staff and assumptions. It varies from department to department. There's quite a high level of prejudice. There is a serious lack of understanding of the nature of drug use.'

In contrast, another employee within the same organisation commented:

'Access is the only problem, from once they access the service, they are treated equally.'

Another response suggested that homeless drug users do experience the service in a 'different' way in terms of the nature and structure of the service rather than the quality of the service or the way in which it is delivered':

'Some services aren't always structured to meet the lifestyle of drug users – the nature of chaotic drug use.'

'It's different in terms of how they are able to access our services in the first place. The way we structure treatment is through community based services. We try to set up community based treatment centres in local communities and have been quite successful – despite difficulties and opposition. (The 'not on our doorstep' attitude). When services

are set up, people from the local community (insist) that local treatment centres only deal with people from the community (afraid of influx from the whole city). Homeless people are often considered not to belong to any area, so the structure can exclude people by its very nature.'

'The waiting list can work against homeless people – when their turn comes around there can be a difficulty finding them or the motivation which may have been there – may not be there any more.'

Other interviewees involved in the provision of homeless accommodation outlined distinctions:

'I always ask 'is there anything I need to know?' The rationale for this is needing to know if there is any potential threat to clients or property, specifically arson, aggression/violence, or previously barred from somewhere else. Active heroin users are not accepted – it doesn't work, as it is illegal and we cannot have it on the premises.'

This interviewee added that there are no written selection criteria and no written acceptance of referral procedures. There are a set of house rules which are read to all residents when they arrive. These state that drugs and alcohol will not be tolerated on the premises. Residents must sign these in order to stay. Having the house rules is a requirement of the local authority who examine the draft and advise on them. House rules outline the consequences if rules are breached. This interviewee accepts drug users who are on programmes. Everyone is initially accepted on a one-week trial basis 'to see how it goes'.

Another interviewee also involved in the provision of B&B accommodation described the way in which her service operates differently:

'If people have a broad Dublin accent we just ask them directly are they homeless. We prefer not to take them because of all the trouble we had....if a person turns up with black bin bags or no bag we refuse them too.'

This judgement is based on 'bitter experience'. Reference was made to; 'receipt books (having) been fiddled and stolen'; 'I have had the welfare onto me because of it,' burglary and 'the feeling of being dumped on by agencies to 'mind' people when she 'doesn't know what she can expect.' This interviewee demonstrated that she has compassion for those who are homeless and feels it could happen to anyone. She also said:

'You can't tar everyone with the same brush-there are some very nice people too.'

She added that it is not the person but their behaviour that matters, indicating that people who need help will be 'taken on' but only if they are given support and can cope in that (B&B) type of environment.

Another response focused on the nature of the behaviour:

'Each case has its own merit – in an individual way. What would affect the situation would be the behaviour. Bad behaviour could be related to using, but not necessarily.'

6.4   Organisational policies in relation to homelessness and drug use

The interviews with service providers found that informal policies and procedures develop over time (but remain unwritten). They also suggest that the interpretation of procedures is subject to individual discretion. As a consequence, the quality of service experienced by a client can to a large extent be dependent on which individual s/he comes into contact with.

The local authority interviewed does not have specific policies in place in relation to either homelessness or drug use. In the course of the interviews, one of its staff outlined ways in which it operates, describing it as 'Council Policy'. Another local authority interviewee, in response to this question referred to 'the lack of expertise within (the local authority) in this area' and suggested that other services including the voluntary sector had that expertise, adding that working together to address issues was the way ahead.

Another interviewee commented on the implications of the absence of local authority policies in relation to homelessness. Specifically, reference was made to women who have to leave home because of domestic violence and who therefore have technically 'made themselves' homeless while clearly not having an option to stay in their homes.

One interviewee with a health board commented on the absence of formal policies but suggested that informal policies develop and become part and parcel of regular practice. It was suggested that this is to ensure the client derives the maximum benefit from the service; 'You would look for ways to help out'. However, this interviewee added that the service would benefit from the adoption of formal policies as the current system is discretionary:

> 'They should be policies, not guidelines. There are a lot of temporary staff – they don't have set knowledge. In the end it does come down to the interpretation of different superintendents. The quality of service should not be dependent on who's on duty on any given day or when they've new staff in. People see things differently.'

An interviewee, involved in the management of homeless accommodation also referred to the high level of discretion which is applied in the absence of policies and procedures. Responsibility rests with the manager whose job it is to see the accommodation is well run with 'no major incidents or damage'. The manager has a 'free hand' with 'power to make decisions on the spot'. In practice, it was suggested that this means if the manager is interested in the residents this will be reflected in the service, equally, if the manager is a poor manager this will also affect the residents. Subsequently, the way in which the service is implemented in practice is determined by the lease with Dublin City Corporation. The house rules are the main source of policy as the way in which the property is run emanates from this. The manager also has contact with community welfare officers and the Gardaí who advise on matters relating to incidents as they arise on an ad hoc basis.

A hostel worker interviewed also referred to house rules as the means by which clients are made aware of policies and procedures:

> 'They are pasted on the wall. It is meant to be a drug- and alcohol-free environment but people still smuggle drugs in somehow. There are security guards in uniform admitting the men in the evenings and they search them and use a scanner but still the drugs get in. We will take in anyone as long as they can stand upright unaided.'

This worker added that possession of drugs on the premises is a barring offence. Subsequently, there needs to be 'three clean urine samples' and residents 'must go through the social worker' to get their position reviewed. In this hostel, the worker referred to the fact that 'instructions come directly from (the local authority)' but if they are 'unworkable' the staff discuss it. It is then brought back to the local authority to 'fight it'.

One interviewee who works in the area of drug addiction commented that the issue of homelessness and drug use is integral to the extent that there is no need to develop separate policies within the organisation:

> 'Drug culture and homelessness are married together. It's implicit. The project has an open door policy. We respond to crises.'

Other agencies operate an unofficial policy:

> 'Work on the addiction, work with the family, work on the homelessness. The priority is to get people into treatment quickly and to encourage them to stay at home.'

6.5   In the absence of policies – informal support?

The absence of formal policies and procedures has two implications. Firstly, it affects the way in which services are delivered by agencies and leaves their delivery open to individual discretion. Secondly and arguably equally as importantly, it will affect the extent to which the complexity of problems being experienced by the client is addressed, or not, as the case may be. In other words, it will have an effect on whether someone's problem drug use is given any attention by those responsible for the provision of accommodation or whether someone's accommodation needs are taken into account by agencies dealing with drug addiction. Given the integrated nature of both issues as outlined earlier in the report, this is important in terms of the effectiveness of any given service.

Interviewees who are responsible for dealing with homelessness were asked whether they offer additional support to clients in relation to their drug use. One interviewee within a local authority does not see it as being part of its remit as its role is specifically as a *housing* authority. It is staff who would, however, refer people to relevant agencies. A member of the authority's front-line staff added the following:

> *'If it is known that they use drugs then they are given a contact number for drugs services and encouraged to seek a place on a treatment programme. I don't know if it's a policy but it's a general thing within the Council that if we do come across people who are problematic drug users we would encourage them to do a course – a methadone programme or something like that… or to get in contact with somebody who can give them help in relation to their problem. We ask them to then get back to us and let us know that they were making an effort themselves.'*

Adding:

> *'They still go on the register. What we need to basically find out is that they are willing to help themselves, that they are willing to do something. The policy is that we are not against people who are using drugs but we are against people that are going to be using their house to sell drugs or hold parties or that kind of thing. But people that have addictions themselves we would just encourage them to seek help.'*

An interviewee, with responsibility for dealing with homelessness said:

> *'There is no support – plain and simple – no (adding that staff try to give people help and flag them up to the CWO or public health nurse so that they know 'that this person needs help').'*

6.6   Anti-social behaviour

The definition of Anti-Social Behaviour (ASB) in common use is the one outlined in the Housing Act. One local authority interviewee indicated an understanding of Anti-Social Behaviour as being; 'intimidation and drug dealing'.

The local authority interviewed is currently developing policies around Anti-Social Behaviour as a requirement of the Operational Plan attached to the Homeless Action Plan. All local authorities are now required to develop a policy on Anti-Social Behaviour and to feed it back to the Homeless Agency. There were mixed responses within the local authority about the current situation. Two interviewees referred to the fact that policies are being developed, one indicating that there are none at present and the second indicating that there were internal guidelines but no formal policy. A third interviewee was unaware of whether or not the Council had any policies in relation to Anti-Social Behaviour.

The issue of Anti-Social Behaviour appeared to be a vexed one for all interviewees and different agencies offered considerably different perspectives on the implementation of this aspect of the Housing Act.

6.6.1   A local authority perspective

While the local authority described a clear procedure which took place over a long period of time and was evidence based others had differing opinions as to how this operates in practice.

In response to a question on Estate Management policy the following procedure on Anti-Social Behaviour was outlined by a senior figure within the local authority:

1. The complaint is investigated with the purpose of establishing its legitimacy. For example, if it is a case of assault – a check is made with the Gardaí. The person making the complaint is also interviewed.
2. The person against whom the allegation is made is subsequently interviewed. S/he is given an opportunity to respond to the allegation. The issue may be resolved immediately.
3. A verbal warning is then issued, followed by a written warning and finally if it's not resolved, the Allocation Support Unit Officer would create a 'notice to quit'.
4. The manager has to sign the Order.

This happens over a long period of time and only after everything else has been exhausted. However, another local authority interviewee, in outlining the procedure presented one which differs to the previous version;

> 'They get a report from the residents associations as well as the guards. If a house is coming up in an area and they have 5 names – they give the 5 names to the guards and they also check them out with the residents' associations as well. More often than not the residents association know more about the people because they are on the ground so they come back and say ' so-and-so is grand but her fella is a big problem' – so they're vetted – with the residents associations as well.'

Another local authority interviewee referred to it in this way:

> 'The current situation is that there are procedures some of which are written and some verbal. Initially there is an informal approach in cases of alleged Anti-Social Behaviour, then this is followed by more formal interview. Most people in the job would know what to do.'

According to the senior staff member investigations in the course of this procedure include liaison with a range of other agencies including the Gardaí and health boards. The local authority interviewed currently has 200 'live' cases on its books.

One of the local authority interviewees suggested that that the external perception of the extent to which the Anti-Social Behaviour policy is used is greater than the actuality and referred to the fact that there have only been seven evictions since 1997. Reference was made to the fact that 100 houses had been abandoned with a suspicion that the occupants were:

> 'big-time drug dealers who left because the heat got too much and they had the resources to up and leave.'

Another local authority interviewee suggested that people tend to surrender their tenancies because:

> 'They would be afraid no local authority would touch them again if they had been to court and been branded as Anti-Social Behaviour by one Authority.'

In terms of effectiveness, one local authority interviewee referred to it as 'a fairly blunt tool'. Reference was made to it being problematic because it took decisions away from District Justices and the local authorities don't have to produce any evidence.

One interviewee referred to it thus:

> 'Excluding orders are a more positive method as the perpetrator of the Anti-Social Behaviour is the only one who is moved so the whole family do not suffer. There are problems when seeking excluding orders through the courts. (We) like to get the family to work with them on exclusions as unless this happens the legal side is difficult.'

A question on what amendments to Anti-Social Behaviour policy as it currently stands would be useful from a local authority perspective also yielded a response in relation to exclusion orders:

> 'I would include a greater emphasis on exclusion orders – this could prevent a situation where the whole family would be evicted.'

6.6.2   Other agencies' responses to drug possession

An interviewee involved in the provision of homeless accommodation spoke of how possession of drugs is dealt with in practice:

> 'We would tolerate the person if they were discreet and not affecting others in the property. There is zero tolerance of suppliers.'

Reference was made to one or two instances where potential residents were suspected suppliers – there was immediate cancellation of their booking. In these instances, it is the Community Welfare Officer who cancels the booking and transfers the resident in question. Suspicion is sufficient for this to happen on grounds that others in the property must be safeguarded. Gardaí inform the service if there is a known dealer on the premises and if s/he is currently dealing.

6.6.3   Dealing with convictions of anti-social behaviour

One local authority interviewee spoke of the difficulties of re-housing people who have been convicted of Anti-Social Behaviour. He suggested that attempts are made to accommodate people in transitional housing, particularly in the case of 'vulnerable people'. However in other cases, further specific information on individual circumstances is sought.

The difficulty from the authority's perspective is striking a balance between the need to accommodate people with previous convictions and the need to consider the reaction from other residents to people with previous convictions being housed in their communities.

One local authority spokesperson referred to the lack of options in such cases. Reference was made to the possibility of private sector housing but this is limited given the 'serious resource implications' in terms of rent allowance.

Another local authority interviewee commented:

> *'If you are evicted for Anti-Social Behaviour, I don't think the Council have to house you again or have to re-house you. I don't know if there is a certain amount of time when you have to come back or whatever. It's all up in the air really, but I was under the impression that if you are evicted for Anti-Social Behaviour then the council don't have to re-house you again.'*

Another local authority respondent was of the impression that people evicted for Anti-Social behaviour are given another chance:

> *'The policy is to give them a chance if they can prove that the problem no longer exists and can show evidence that they are living trouble-free. There is no timescale for this as it varies from case to case. Evidence includes a paper-trail including letters to prove   they have reformed and are no longer a threat to the community. This is a very difficult process with rough sleepers and anyone who has been homeless for 3 years plus… some checks are done by (the local authority) and some by the client or at the least the client must provide a contact for verification to be checked by the Authority.'*

6.6.4   Other agency perceptions of local authority procedure

Respondents in other agencies suggested that the actions of the local authority deviate considerably from that which was described as the procedure:

> *'There's no programme that can stand up in court. Anti-Social Behaviour is a nightmare for us. We have to investigate why people are homeless. There is rarely evidence produced. Nobody has hard-core evidence. There is nothing definite.'*

Furthermore, one interviewee commented on the official and unofficial implementation of this policy – a response which differs considerably from the position as presented by the local authority:

> *'There is very little eviction for Anti-Social Behaviour. The law doesn't have to be at the site of an eviction. We get notice of evictions. A lot of the time the reason given is 'rent arrears' and Anti-Social Behaviour is put down in brackets beside it. Rent arrears is easier to prove in court.'*

There is also a problem in terms of the absence of a policy to re-house clients evicted as a result of use of the 1997 Housing Act whether directly or indirectly:

> *'There is also no commitment to re-house. One couple evicted for anti-social behaviour were in transitional housing for six years. They're referred to transitional housing to build up credibility.'*

> *'What we're looking for is an answer to what do they have to do to be re-housed? What do they need to do? Sometimes it's the 18 year old (but the family gets run out or evicted) – if they get rid of the 18-year-old, what then? It's not always the client. A lot of time – there is community pressure.'*

'One of the problems I have with it (and I understand the reason for it – if Anti-Social Behaviour is upsetting whole communities) is that it is an indefinite sentence. There is no clarity on how to get people back into the system. It is beginning to change – the Council is trying to change, but it leaves people in limbo land. It's good management to deal with disruptive behaviour, but there must be a way of getting people back into the system'

The issue of Anti-Social Behaviour is further complicated by the fact that people leaving property because of alleged Anti-Social Behaviour is not always officially driven:

'Local communities take the initiative themselves. They're not strictly evictions – the communities run them out. They would be in fear of their lives if they returned.'

6.6.5   Post imprisonment

The local authority was asked to comment on a situation described by other interviewees, that is, on the difficulties experienced by people who had been imprisoned and subsequently lost their place on the housing list. This was particularly problematic for people who had become 'clean' in prison but became homeless on release and subsequently found themselves in drug using company again. One employee of a community drugs project commented:

'You can't get on the housing list from prison – therefore you're not on a priority waiting list – you're homeless straight away after you leave prison – it's a problem especially for young men.'

One agency working in the area of drug addiction suggested that their premises be used as an address but added that this was not acceptable to the local authority.

The Authority's response is that its procedure involves an assessment on the basis of current circumstance alone – if someone is in prison – that is their current circumstance. Reference was also made to the complexity of the issue from its perspective as an authority which has to take a range of needs into account in its decision making. For instance, consideration must be given to to the nature of the offence for which imprisonment took place; an example was given of someone being convicted for assault on a neighbour and the difficulty faced by the authority in re-housing that person in the same area.

6.6.6   Inter-agency sharing of information about anti-social behaviour

The provisions under the 1997 Housing Act for housing authorities and health boards to 'make enquiries' of each other to inform their own assessment procedures appear to be loosely applied. Staff seem to rely on informal networks more so than the development of formal mechanisms for dealing with queries and requests from other agencies.

'It doesn't arise – because both agencies would have similar levels of information. I'm not aware of it (the provisions under the Act) being used – I can't imagine the context in which it would be.'

'I would be more reluctant to give information if it was negative information about the person. But there is no policy or procedure in the Unit.'

Asked to comment on whether information from other agencies with regard to Anti-Social Behaviour would be used in making a decision about rent allowance one interviewee (whose job involves responsibility for placing people directly in accommodation) referred to the fact that the issue of rent allowance doesn't apply and that this eases the issue of service delivery:

'In the Homeless Unit here there are certain things we can do that local area officers can't. There's a big advantage to it, you're not putting barriers up with a client – it makes the job easier'

6.6.7   Other options

Another agency suggested that the Council is open to those who can prove that their behaviour has changed:

'The (local authority) assesses individual cases on merit. They are much more open to people who have verified they have changed their behaviour.

One interviewee working in a role other than directly dealing with accommodation referred to the role its agency can assume in relation to Anti-Social Behaviour:

'For example with reference to Anti-Social Behaviour – in private rented accommodation, when landlords are thinking of kicking then out, but there's no proof, we would talk to the individuals – because we would have a personal relationship with them. We refer to knowing about wild parties, we don't mention drugs-we make them aware – you were homeless, now you have a place to stay, take care of it. Because I'm a long time in the job, I know them from when they were 5 or 6. I don't refer to drugs, but I know they know. I don't delve and I don't be stuffy about it.'

6.7   Lack of inter-agency response

The lack of an effective inter-agency response or set of co-operative procedures was highlighted by numerous interviewees. Many respondents appeared frustrated by the limitations of dealing with a complex set of problems on a single issue basis.

6.7.1   Need for integration

Interviewees highlighted the fact that clients have to go through the same process of assessment, interviews and form filling with a number of agencies. One interviewee employed by a statutory agency commented:

'(Homeless people) are form filled to death – everybody wants a bit of you.'

This interviewee added that, frequently, information isn't shared in the interests of client confidentiality but argued that it is often in the clients' interest to share information, as it saves time having to repeat assessment processes with a number of different agencies. He suggested that 'informed consent' of the sharing of information would speed up agency responses.

The need for an integrated inter-agency response was regarded by most interviewees as crucially important in dealing with homeless drug users as such a response, they suggested, is the only one which would reflect the complexity of the issue. Indeed many suggested that where homeless people are also drug users, the issues should not be dealt with separately.

'We would try and link them up with other agencies. For instance we would refer people to drug treatment programmes, but it's up to them whether or not they take them on. (A more structured) relationship would be useful – more communication between the different agencies.'

'Addiction is only part of the problem. Homelessness is the whole problem – low esteem, literacy – a tight integrated approach is needed.'

'It's about trying to encourage people not to be so building focused – to look at coordination of services. Homelessness and drug use services – there's no need to separate the issues.'

'What we would like to do is to provide drug treatment services in homeless hostels, we are hoping to do that… there can be difficulties and resistance, but we're hoping to get at least one off the ground this year.'

'One of the big things would be an improvement on communications with other service providers. Front-line staff need to sit down together.'

While there is differing emphasis on this issue – there is a consistent message – separating services has limited value.

Others referred to a lack of inter-agency knowledge on each other's roles and responsibilities:

'I don't even understand the Council – there's a homeless section up in Tallaght and don't ask me what they do. I haven't a clue. I don't know what is going on over there.'

This was related to inter-agency perceptions and was raised in a number of interviews. A few respondents referred to the fact that they were perceived in a negative way by staff in other agencies. It was suggested that each agency has insufficient information on the role and indeed limitations of others. This can affect expectations and subsequently judgements in terms of the commitment and effectiveness of other agencies.

'My impression is that we have a bad reputation. It's very rare that we would sit down and discuss things. There needs to be more links – extra meetings, that would improve things.'

One interviewee referred to an inter-agency presentation which had recently been delivered and commented that it made 'a huge difference' as it was the first direct communication on the actual role of the service.

Others spoke about the level of confusion for clients who are in need of a service or support but would, in the main, be unaware of the varying responsibilities of the different agencies:

'Information is lacking. People are put into the accommodation and then left. The community welfare officers visit once a week. They should be given a leaflet to tell them where local services and contacts are and to help them to settle. They should be given an information pack like refugees and asylum seekers.'

One interviewee involved in hostel accommodation offered a different perspective:

'Drugs services should be separate. This is a crisis lifestyle where you get problems compounded with older men being robbed and their prescription drugs taken off them. Drug users do not mix with the alcoholics or with the older guys who are afraid of them. They need somewhere separate, as in a hostel such as this, if they turn up in any numbers there is chaos with robbing everything and all the mobiles going missing.'

6.7.2   Which issue first?

While basing their responses on the premise that an integrated response to the needs of clients is essential, there was also broad consensus that the homelessness of the client must be dealt with as a matter of priority – that drug addiction could only be dealt with effectively if clients had a 'roof over their heads'.

'The homelessness is dealt with first and foremost. The drug use is a 'by the way' need – the most important thing is having the four walls.'

6.8   Barriers within the systems

Those responsible for the delivery of services highlighted their limitations and referred to certain procedures which can affect the quality of service a client receives.

For instance, opportunities to access drug treatment programmes is problematic for people who are homeless as an address is required in order to be placed on a waiting list. In some cases when the person in question has been asked to leave by the family because they are using, the family does not allow the home address to be used.

'They can't access services because they're homeless. You can't really deal with someone's drug use when they're homeless – they're caught.'

Another interviewee referred to the criteria applied for priority housing, highlighting the fact that:

'the system is encouraging young girls to get pregnant to move up the housing list.'

6.9   Lack of local responses to the issues

The majority of interviewees highlighted the extent to which the absence of a local response to homelessness is a major problem. Participants spoke of 'exporting the problem' out of the area. They highlighted two significant consequences. Firstly, 'moving people out' means that agencies based in Tallaght do not develop their capacity to create the integrated local responses needed to deal with the problems of the client group. Secondly, there is lack of community ownership of the issue of homelessness, the implication being, lack of visibility means diminished responsibility.

This clearly has an effect on the way in which service providers can engage with the issue of homelessness:

'For example, if you present to the SW board, the first priority is to provide accommodation and they move them out of the area, so they lose contact with the service. Clients are referred on a lot. The local community care teams focus more on child protection issues. Homelessness is moved into the city centre.'

With reference to the community ownership issue, one interviewee suggested that parents would adopt a different attitude if the problem was actually dealt with in the Tallaght area.

'We need somewhere in Tallaght – we would be looking at getting people settled back. It's more likely parents would take them back – they would not want their sons or daughters to be seen using the hostel if it was in the area. If there was a hostel here, the community would sit up and take notice, what's happening at the moment is that they're moving the problem around and out of the area.'

'We need something to keep people in the area.'

6.10 Lack of resources

There are insufficient resources to meet the increasing needs on services. One interviewee working for a statutory agency commented that the 'system is clogged' referring to the fact that there are 6000 people across the city trying to access the services.

One interviewee who works in a hostel for homeless men referred to:

'Seeing on average 30 per night in some capacity, including crisis counselling. (We are totally) overworked – often we are just like an agony aunt for the men, listening to their whole life story.'

6.11 Lack of political will

A recent inter-agency initiative has been developed in Tallaght to progress the development of purpose-built accommodation. A number of respondents referred to the difficulties in progressing the issue because of 'lack of political will'. The issue of addressing the needs of homeless drug users was described as a political 'hot potato'. However, some of those involved spoke of the absence of political will as a major stumbling block. One interviewee commented that it becomes particularly difficult when attempting to develop accommodation for young men adding that there is a higher degree of community tolerance for the development of services for young women and children.

One interviewee pointed to the fact that political resistance to developing local solutions reflects thinking within the wider community:

'Drug users are not wanted, their behaviour is seen to be a risk to the community, people feel threatened.'

The difficulty of addressing the accommodation needs of young men was also referred to by an interviewee presently involved in the management of accommodation for homeless people (albeit in a different context).

'It's not right that single men are in with mothers and children. They tend to be aggressive.'

6.12 Training

6.12.1 Training on homelessness and drug use

Broadly speaking, the availability of training for staff on the specific issues of homelessness and drug use appears to be quite limited although in general staff seem to be quite well supported by the availability of generic training. There was an inconsistent response within agencies to what is actually available in terms of specific training on the issues of homelessness and drug use – some interviewees within agencies commenting that there is *'regular ongoing training, raising awareness of the issues'* and others saying there is none available, adding that a lot of learning takes place 'on the job':

'You pick it up as you go along, you learn on the job.'

One interviewee laughed in response to a question on training:

'I wasn't given any training for the job… I was told on a Friday you have to move and start on Monday. (The person who did the job before me) was there with me for the first week to generally show me the ropes but I didn't receive any training or anything like that. One of the questions that (s/he) told me to ask is – if they are on a methadone programme – to ask how many milligrammes they are on per day. That means nothing to me, most of them are on 80 but they might as well be saying I have ten bananas a day. I don't know what that means whether it's good or bad – it all goes down in the report.'

Some agencies provide training on an ongoing basis. Case meetings are also a feature of some agency's work and are considered to be a valuable way of allowing time for discussion of the issues.

Some respondents commented that specific training of this nature would be very beneficial:

'It would affect personal opinions about users. It would help understanding. There needs to be more listening to what they have to say. It would reduce negativity. There would be a better service.'

'In the first couple of weeks I got quite a shock. Some form of training would have been very beneficial. It would have been beneficial to me and also to the service I could have given. It would have been useful in terms of how to relate to people. For instance, the   language to use – language that would not be offensive, language that would be encouraging.'

'If I have to tell them bad news I have to tell them bad news they just take it or whatever and obviously some people wouldn't like doing that but obviously if I had training I would be able to do it a hell of a lot better.'

The difficulty for staff in attending training was highlighted by one interviewee:

'Training is a difficult one as there is an opportunity cost – people are out of their jobs for the day. Then there's the actual cost. But, there's no resistance to training – you don't need to convince people of the need for it. There's just practicality issues.'

Comment was also made on the limited effectiveness of training, suggesting that it will only make a difference if accompanied by an increase in supporting services:

'I don't think training should be compulsory, it could be encouraged. All staff should be aware of the issues. You can have all the training you like, but staff will say – we have no services to refer people onto.'

Commenting on what informs practice in the absence of training and policies, respondents referred to deferring to their own years of experience or that of other members of staff, for example:

'Experienced people would say, 'comeback when you're functional' – they would refer to the 'condition you're in'. Would not refer to drugs. New people would talk to an experienced member of staff. Personal relationships are key to success. However, having a policy in place would mean everybody would be treated equally.'

'A lot of people here have those skills – they have an idea of where people are coming from – they have a feeling for it (empathy, know how people are feeling), but it's a result of personal skills not training.'

One interviewee responsible for the management of homeless persons' accommodation referred to training she had attended which was organised by a local authority for front line staff and delivered by Merchants Quay. This was a pilot session run in February-March 2003 and consisted of six one-day sessions. The interviewee felt this gave her an insight into understanding homeless drug users and information on handling drug incidents. Reference was made to:

'seeing drug users in a different light – being more able to understand them.'

In one of the hostels, training is also availed of:

'This is starting to happen. Only the key workers have drugs training and are qualified addiction counsellors. The security staff are contracted from a security firm and have no training other than what they get on the job.'

In relation to this hostel, it was noted that:

'Nothing comes from (the local authority) or the Health Boards, if anything happens we make it happen ourselves.'

6.12.2 Training possibilities

Reference was made to the training provided by the Homeless Agency which is available for agencies dealing with homelessness.

It appears that training will be made available under the Social Inclusion Programme within the health board:

'We'll be looking at training as part of the social inclusion work, for example on inter-cultural issues. It's difficult to get people to see training as a priority. We're hoping to include it as part of induction training and that the social inclusion concepts would be included as an approach.'

6.13 Drug-related incidents

None of the interviewees had been offered or were aware of the availability of training to deal with drug related incidents. Others interpreted the question as suggesting that this referred to aggressive behaviour:

'We would deal with behaviour as it presents. There would be a level that we would tolerate. Staff do respect the imbalance of power. We don't have a lot of incidents – in fact there's very little of it. We don't tolerate aggression. We have a 2,600 client turnover. Only five or six people have been barred. We exert a certain tolerance for a level of verbal aggression, but we have a cut off point.'

One interviewee commented that this should be included in generic responses:

'It's not necessary – there would be health and safety policies. We would try not to differentiate.'

6.14 Appeals systems

Interviewees were asked to comment on whether there was a mechanism for clients to feedback or lodge a complaint or appeal if they believed the service they were receiving was inadequate. There is an appeals system in place within the local health board (the appeal can be made verbally or in writing). However interviewees did not have any specific information on the extent to which this was used by homeless drug users as the method of recording appeals does not make distinction between clients. This information, it was suggested, would not be relevant to the complaint. It was also pointed out that clients are unlikely to disclose being a drug user if they are issuing a complaint.

One interviewee also highlighted the fact that the appeals system takes time and this does not suit the needs of this particular client group:

'People have a right to appeal but decisions are not often overturned. Appeals take too long (given the likely nature of the crisis).'

One statutory agency commented that the volume of complaints would be limited and not always directly related to services provided by the agency, but rather those to which they refer people to:

'It's not always about our own services, sometimes it's about approved hostels for instance. People send it to me asking me if I want to comment. In fact it's often about services we don't directly provide because people don't know what else to do with the complaint – there's nowhere directly to send it. But it would be very few.'

In one agency, each client has a designated worker, if there are outstanding issues which are not addressed by this staff member, the project coordinator is available.

In one of the hostels, the male residents have access to the CWO or a key worker to make a complaint. Internally there is a report book in which complaints are logged in triplicate for recording purposes. Complaints are then raised at staff meetings and management deal with them.

'This is a private hostel. The key worker can deal with a complaint on the spot against a security man (described instances where they have got rid of security men after a complaint from a resident). The normal policy is three strikes and you're out.'

6.15 Links between homelessness and drug use

All interviewees were asked to comment on whether they perceive there is a direct link between homelessness and drug use. There was a broad consensus that the two issues are inextricably linked.

One local authority respondent suggested that it is a 'contributing factor' as 'drug use creates chaotic lifestyles' and simple tasks in house maintenance and retaining rented accommodation can be very challenging.

Most interviewees offered stronger positions:

'They go hand in hand. If somebody is very active (in drug use) in the home – they're not functioning. Parents can't cope – they can find themselves chucked out – it's the invasion of chronic addiction.'

'Yes and conversely, homelessness leads to drug use. There's lots of homeless people NOT on drugs, but it can lead to people re-starting. They get on the roundabout of depression, the situation, the company.'

'It works both ways. Some people become homeless because they're drug users and vice versa. People get trapped in a Catch-22 situation. Homelessness prevents people from dealing with their drug issues – it's the challenge we're trying to respond to.'

'Yes. There is an under culture living out there. In the dead cold of night – polydrug use – you find yourself in a culture of homelessness and despair. There is an increase in prostitution – it's linked to cocaine. There is the finance issue – the guys are encouraging their girlfriend to go into prostitution – for quick money. I know of about $^1/_2$ dozen in the last 3 weeks. The money means you can afford decent B&B's.'

'Without a doubt. In the majority of cases, drug use causes homelessness. For example, the father is an alcoholic, can chuck the kids because of their behaviour, can lead to drug misuse. It works both ways.'

'People may not be using initially but they get in with those who are and become involved because they meet them when they are living in temporary accommodation. This comes from vulnerability – people are thrown into homelessness for whatever reason and are susceptible because of despair. They are looking for a bright light in the darkness.'

'Yes, definitely. The family usually puts up as much as they can and then throw the addict out. Prescription drugs are a big issue along with painkillers and methadone. GP's have not understood the situation as regards methadone. People get clean off the heroin and hooked up with a methadone programme but within a week they are using again despite this.'

Clearly for those working in drug treatment services the homelessness of the client is a major barrier to addressing the drug addiction.

'If they have a roof over their heads, then positive work can be done. The basic requirement is a roof – then we can start to do the positive work. Even if it's not ideal accommodation – you've no chance if they're walking the streets. Their self-esteem and their confidence is in their socks – all they can describe is despair and a big, black pit. You work

through the despair, when they get a home, they can move on really quickly – when they're warm, etc'. With despair – there's no motivation – they've got to stay linked into the services.

'Homelessness causes drug use to spiral out of control.'

Similarly it was suggested that the provision of a home could be a crucial first step on someone's road to recovery:

'People with adequate support have done extraordinary things. With support, encouragement and motivation – they have done extraordinary things to pull their lives back together again.'

Clearly – there is a strong body of opinion which suggests that unless one issue is dealt with the other will be impossible to address. One interviewee working in the area of drug addiction referred to a recent case where someone had been on a detox programme – was clean, but had nowhere to go to, became homeless and ended up back on drugs:

'The service can let them down. With homelessness – relapse is inevitable.'

6.16 Challenges presented to agencies

Given the complexity of issues as outlined in previous sections of the report and the immediate and crisis nature of the needs of this particular client group, interviewees were asked to comment on whether working with homeless drug users presented any particular challenges to them in the delivery of their services.

Some respondents referred to difficulties:

'It's quite difficult. If somebody is rational and in control, it's much easier to get a picture of the circumstances – than if someone is high on something – it can be difficult for them to speak, to get information and they can be quite aggressive. At times they can be violent, staff here have been attacked. They really want good news and they don't want to be given bad news. We very rarely have good news – it makes it doubly difficult'

'Drug users are not always easy to deal with as clients.'

'The most 'crisis' of all the clients in crisis are the homeless drug users – they take all your energy. You could go round in a circle with these men – there's an 'unfillable' need. I would work with five alcoholics more easily than 1 drug addict because of the high care needs and desperation. I would nearly say hopeless. The only chance they have of success is to take them to Tullow away from all their rotten friends and get them a new start out of the city.' (She describes how people go there and do well and even have jobs and permanent accommodation, but when they return to Dublin they meet their old friends and they are back to the start again).

Other interviewees referred to difficulties in terms of service delivery as 'normal' procedures do not readily apply. One person referred to the difficulty of people presenting as homeless, coming in for initial assessment, not returning and there being no way of finding out what has happened that individual:

'A letter is sent and it says if you do not contact this office within 10 days or 14 days your file will be closed. If they don't reply to letters then you ring up to check if they're still staying there, more often than not they've left or they've moved onto another emergency accommodation.'

Reference was made by a local authority respondent to the fact that the authority is limited in what it can do as it is restricted by the availability of housing stock. This is not always understood by other agencies:

'At times, people have tried to bully us (social workers etc.) – they think that by constant phone calls, letters, we will eventually 'give in'. But we have to do a fair job and do the best job we possibly can for everybody. Everybody's problem can't be solved and all problems won't be solved by people having a roof over their heads.'

An interviewee who works in a hostel for men spoke of the challenges presented in terms of their service:

'Keeping the drugs off the premises and lowering risk for all clients is difficult as no matter what is tried drug users will always get drugs into the hostel. They are high support and hard to help in terms of successfully kicking habits especially when they are on the circuit where they are constantly in the drugs environment.'

One interviewee within a local authority referred to the challenge she is personally presented with in terms of the absence of training:

> *'The main thing is that I don't really understand – I don't understand what it's like to be addicted to any kinds of drugs or anything like that. It's like I'm from a foreign land and I'm looking at them thinking where are you from? I'm trying to treat them the way I would treat other people but obviously they need some kind of direction and all I give them is a phone number – that is all I can do – I know no more.'*

6.16.1 Appropriate accommodation

One interviewee who runs a B&B referred to the challenges she is presented with in the context of the appropriateness of this type of accommodation to meet the needs of the client group. The response, although quite specific, is consistent with other responses which question whether the service they are responsible for delivering is the most appropriate. The implication here is that it is inevitable that challenges and problems will arise.

This respondent's B&B hosts a mixed clientele including vets, doctors on locum, nurses, tourists and people who are homeless. She outlined in detail a very bad experience. She stressed however that not all homeless drug users are the same – there are 'good and bad' and she has experience of both, adding that *'it is not who people are that counts but the way they behave'.*

She described a situation which had occurred the previous day. There was a homeless drug user staying at the premises. He had been there for four days and she had *'no reason to think there was any problem with him'* as he *'was very nice'.* The previous morning he had asked if he could make a cup of tea, she said yes and left to go shopping, leaving him at the kitchen table drinking tea. She met an ex-client who was a homeless young man who she had gotten on well with. He carried her shopping home and she brought him in for a cup of tea. When she got to her house:

> *'It was wrecked: the doors of all the rooms where people were staying had been kicked in and there was blood everywhere in his room. He told me he didn't want me to go in only once a week to change the bed, so I respected his privacy and didn't, but the room was full of blood and broken needles. The throw was stained and the bed soiled, and everything was just upside down. I couldn't believe it and thank God I had the other young fella there with me. The bedroom window was open so he must have been disturbed by us coming back and left.'*

She was visibly upset, shaken and quite distressed, and went on to describe how her personal belongings had been taken including jewellery of sentimental family value. He had broken glass, opened presses, and *'smashed the place up very badly'.* She was worried about the other resident who was a drug user. Her room had been broken into and methadone robbed from it.

The empty bottle was left in his room. She said that her reason for relaying this incident was to illustrate the challenges she is presented with as a private person accommodating people with high need.

She compared this with a referral from a drug treatment centre. She feels that it supports not only the client but also herself as the accommodation provider. There are daily visits and phone calls to see 'if everything is ok with their client'.

6.16.2 No distinction

For a number of the agencies, 'particular challenges' were simply not an issue. One respondent commented on the fact that experience equips one with the ability to deal with situations which arise – but this is not exclusive to drug users:

> *'Experience enables you to deal with problems which arise – but the problems are general – it's not about drug users.'*

> *'Drug users should not be treated any differently – it could be my son or daughter and you wouldn't want them treated differently. Some are not articulate enough to speak to people in authority – their hackles are up – they're expecting officialdom – you talk to them as best you can, as politely as you can. When hackles are up a polite approach can be dis-arming.'*

'What's the difference (between this group and any other)? I don't see any. I feel you're only making the situation worse if you treat people differently. I try to accept each case on its merits. I say to them this is your chance to get your head together.'

This interviewee elaborated by adding (as did others) that she has often thought it could be her in the situation. Others referred to the fact that it could be their children.

'I always put myself in a person's position – if it was me what would I want?'

This interviewee sees that the experience of homelessness is very distressing especially for families with children. She acknowledged that people tend to think of homeless people as drunks on the street and added:

'It's not costing us anything to steer people in the right direction. I feel very passionate about what I do.'

Another interviewee referred to the challenge to clients in being aware of and managing the different criteria of agencies – 'you have to box clever'.

Another interviewee had mixed views when asked to comment on what she associated with homeless drug users in terms of service delivery. She associates it both with 'trouble' and simultaneously with 'feeling sorry for people' and 'wanting to give them a hand' because she 'feels for them'.

6.17 Solutions

In the course of the interviews, respondents offered suggestions for the way in which services could be adapted to render them more effective in meeting the needs of this client group.

6.17.1 Responses

Some responses focused on the need for increased inter-agency co-operation. Most interviewees emphasised the need for greater integration of services.

'An inter-agency approach. Greater sharing of information. A more cohesive structure – agencies getting to work together – it happens informally, but then it's down to the individual.'

It was also suggested that a comprehensive inter-agency response is particularly appropriate for this client group who are not necessarily conversant with the individual responsibilities of each agency. They know they need support and ideally it would come from one source:

'People using the services have no idea what's out there in terms of support – what the different agencies can do. They just need help and approach agencies. But they don't know what the agencies do (or should do) and have no sense of what their rights are. Increase services and create options.'

6.17.2 Accommodation

There was an agreed need for increased accommodation options, and although some offered suggestions as to what the nature of that accommodation should be, many respondents struggled with identifying the most effective response.

Suggestions included:

'For women and children – B&B accommodation. For men hostels with on-site support.'

'There's a great need for more residential places for homeless drug users. In the hostels, people are turfed out at 9.30 in the morning and they can't get back in until 6.00. People in residential hostels, they have more success in getting jobs and in being successful on treatment programmes.'

'Specific housing with supports attached and integrated in it. Drug problem addressed, local services involved, with specific programmes to help them towards surviving in permanent independent housing.'

Another respondent commented:

'Without high support, not many could be placed in permanent accommodation – they have high support needs which distinguishes them from others who are homeless. They would need to go through a number of stages working towards permanent accommodation. Transitional stages of training and support would help them to progress to independent housing. This would be dependent on their being helped to work on their drug problem at the same time. When money is tight due to drug use the rent is the first thing to go and then when the rent isn't paid they are evicted, especially in the private rented sector. There is a need to look at all aspects and their effects on each other when dealing with this client group.'

Some referring to a current initiative which is concerned with purpose-built accommodation have reservations:

'Hostel-style accommodation is not necessarily the way forward without other issues being dealt with hand in hand. All the problems need to be dealt with together. A homeless users' service. A multi-disciplinary approach.'

Another respondent also involved in this initiative suggested that the creation of purpose built accommodation is only addressing one aspect of a complex problem:

'It's not necessarily the answer. There needs to be another type of emergency accommodation – for example that the Council would have housing stock and B&B accommodation – there needs to be good supports in place and there needs to be a continuous approach. There's also a need for preventative work – but if people have to leave, there should be something available locally, then they could move onto structured accommodation.'

It was also suggested that actually *building* a response to the problem is one way of prevaricating on the issue – it takes time and in the meantime, the issue could have been dealt with in a more integrated, integral way.

'The idea of building institutions is dated but it's accepted within the agencies. It's about finding places within the existing housing stock – move towards transitional housing…looking at a green-field site delays dealing with the issues (as there will be planning issues, resistance from local residents, etc.).'

One interviewee suggested that more treatment centres would be beneficial as it would reduce resistance from local residents if they felt that the issue wasn't just being resolved on their doorstep:

'Because there are more treatment centres and the more that are provided, the less of a problem it will be.'

With regard to increasing the quality of some of the services currently on offer, one interviewee who runs a B&B stressed the absolute importance of agency support for people who run B&B's. This interviewee is 'disgusted' at the current lack of support given to both clients and accommodation providers:

'If agencies want people to be accommodated by places like mine then they should be in close contact so we can get support and help to help the client. If this was done things would be different. Dumping people without a word or any support doesn't help anyone.'

Commenting on what would be suitable accommodation:

'There is nowhere suitable for them to go so places like mine are used – the drug patient is just dropped off and left with no follow-up. We are ill-equipped to handle homeless drug users – my B&B is not suitable as the situation currently stands.'

6.18 Other issues

A response to the problem of where one is placed on a waiting list was referred to by one interviewee:

'They have developed a procedure where a certain number of homeless people will get priority because they're homeless – not because of a place on a list. It's an attempt to overcome the waiting list problem.'

In relation to gauging the extent of the problem, one interviewee working within a statutory agency commented that the problem is understated:

'Homeless figures do not reflect what is actually happening. For instance in a three-bedroom house, you could have 14 people staying – it's a ticking bomb.

6.19 Concluding comment

The complexity of issues identified by service users in the previous chapter is mirrored in the experiences of those responsible for delivering the service who also describe a complicated situation.

In the main, those responsible for providing services acknowledge that they are limited by the constraints within which their own agency must operate, and recognise that this can prevent them from addressing the range of a client's needs from a holistic perspective. Drugs services deal primarily with addiction and homeless agencies with accommodation. In the case of homeless drug users these two areas constantly overlap and shift.

This limitation frequently leads to frustration as staff are aware that irrespective of the effectiveness of any agency's intervention it will be limited in the absence of equally effective responses from other agencies with different sets of responsibilities. For instance there is little chance of success in supporting a client undergoing drug rehabilitation in the community while s/he is rough sleeping or in another form of unstable, supported accommodation.

The indirect use of the Housing Act 1997 for dealing with Anti-Social Behaviour is clearly problematic. Service providers for the most part are acutely aware of the extent to which this compounds problems in relation to the experience of homeless drug users rather than alleviates them.

There were strong and consistent messages both from individuals and agencies highlighting the need for; training, the development of organisational policies, an integrated agency approach and a range of Tallaght based solutions. These and other matters arising from the previous sections are outlined in the following chapter.

Chapter 7 – Issues Arising

The combined experience of homelessness and drug use clearly present a complex set of problems for client and service provider alike. For the client, in addition to the physical, social, psychological and emotional consequences of the lifestyle, accessing the right services at the right time and receiving a service which reflects and respects the diversity of individual need is extremely challenging.

From the service provider perspective, agencies are limited, not only by resources, both financial and human, but are restricted by their legal and statutory responsibilities and are usually in a position to deal with only one aspect of a clients' complex set of problems.

However despite this, this research highlighted the fact that there are a number of individuals working within the system clearly committed to making the most of the resources they have to deliver the best possible service to the client.

7.1   Key findings

The key findings which emerged in the course of the research include:

1. There are strong links between homelessness and drug use – a link which is not adequately acknowledged or reflected in either government policy or agency responses:
    - Although the report did not find strong evidence that homelessness contributed to people's starting to use drugs, it shows very clearly that it contributes to both continued drug use, and the nature and extent of drug use. For example, becoming homeless is associated with a transition from smoking drugs (including heroin) to intravenous use;
    - Drug use contributes to people's becoming homeless and also to remaining homeless for long periods;
    - Being homeless makes it very difficult for drug users to begin to deal with their addiction;
    - Drug users have poor experience of emergency accommodation;
    - Homelessness increases risky behaviour among drug users (sharing paraphernalia and unsafe sex). There is a also a high incidence of hepatitis C among homeless drug users in this study and evidence of poor health, both physical and mental, particularly among long term homeless drug users;
    - Being homeless makes people vulnerable to drug use because of the easy availability of drugs on the homeless circuit. This includes within hostels; a significant number of drug users prefer to sleep rough than stay in hostels because of the prevalence of drugs there;
    - Being a drug user makes a tenant in local authority housing vulnerable to exclusion and isolation with regards to use of the 1997 Housing (Miscellaneous Provisions) Act. Becoming homeless as a result of use of the 1997 Housing (Miscellaneous Provisions) Act means a drug user is barred from rent allowance, re-housing, and most emergency accommodation. S/he is forced to sleep rough, stay with relatives or friends, or reside in the most dangerous hostels providing emergency accommodation if s/he can gain referral/admission.

2. The lack of an agreed definition of homelessness has led to an absence of agreement on the nature and extent of the problem, thereby hindering the development of a coherent policy response which includes both statutory and voluntary agencies.

3. The information about what to do and where to go upon becoming homeless was reported as being most readily available from other people who were homeless, rather than from agencies and service providers.

4. Homeless drug users face numerous obstacles in accessing accommodation – some accommodation options are not available to active drug users and homeless drug users are sometimes excluded completely from all forms of accommodation.

5. The system of emergency accommodation actively works against homeless persons vulnerable to drug use because of the ready availability of drugs.

6. Homeless drug users in Tallaght find it virtually impossible to deal with both issues at once particularly in light of the geographical and administrative separation of agencies dealing with the two issues.

7. While housing staff and staff in the HPU on the whole were experienced as discourteous and insensitive to the realities facing those with a drugs problem, there was widespread recognition among service users of the pressures that faced the people working in these services.

8. Staff dealing with homeless drug users generally see themselves as taking a supportive attitude but as not always being adequately trained or resourced to be effective.

9. In contrast, homeless drug users see many staff dealing with them as taking an unsupportive and disrespectful attitude.

10. A change was identified in how responsive services are to out-of-home drug users, with descriptions of previous treatment from the early 1990's contrasting with current experience, which was felt to be improving but not significantly, and depending on individual staff within each service to make it happen.

11. The absence of agency policies, procedures and training specific to the issues of drug use and homelessness means that the quality of service received by clients is frequently dependent on the individual encountered on the day.

12. While the volume and range of strategies, plans and inter-agency groups developed to address both homelessness and drugs would suggest a comprehensive, integrated, inter-agency approach, this is not reflected in practice.

13. The Housing (Miscellaneous Provisions) Act 1997 in its current form is problematic.

14. There is a conflict between implementation of policies within a social inclusion framework alongside others concerned with Estate Management.

These and other issues are addressed in more detail below and will also be considered in the following chapter on recommendations.

7.2   National

1. Despite the widespread government commitment to eradicating social exclusion, agencies working on the ground are struggling for funding to maintain services and people experiencing homelessness continue to face appalling responses to the crises they find themselves in. In the Ireland of 2004 it should be neither necessary nor acceptable to provide a service to people experiencing homelessness (such as the one provided by THAU) which includes facilitating them to sleep outdoors in all weathers, through the provision of sleeping mats and bags.

2. There are strong links between homelessness and problem drug use. This raises a myriad of issues for policy makers and service providers because the nature of this group sets them outside the legal framework.

3. There is no agreed definition of homelessness. This results in agencies with responsibility in this area using different criteria with which to measure homelessness. Subsequently, there is no agreement on the extent of the problem and so brings into question how targeted and realistic suggested solutions can be.

4. Those who are homeless and using drugs are doubly socially excluded. National social policy does not adequately cater for this group, nor does it recognise the reality that for many, to be supported with living in a way that will reduce harm, is their best possible hope. Approaches to the drugs issue have been various and it may be time to recognise that drugs are here to stay, and develop policies which rest on harm reduction.

5. There is a dearth of research into homelessness among the drug using population and conversely of drug use among the homeless population in Ireland.

7.3   Tallaght

1.   There are no homeless services (apart from THAU) or emergency accommodation in Tallaght. This is highly problematic.

2.   One of the serious consequences is that clients indicate increased levels of drug use in the environment of city centre homeless accommodation, as well as polydrug use. It also presents a number of logistical problems for people who are trying to access or maintain links with drugs services in Tallaght while living in emergency accommodation in the city centre. Individuals also become cut off from local support networks. The dispersed nature of services located in different areas presents very real problems for people whose lifestyle is already chaotic and who frequently have little money.

7.4   Homeless drug users' experience of service delivery

1.   There is a high degree of inconsistency in the quality of services received by clients approaching homeless agencies. It is frequently dependent on the staff member on duty on a given day. Policies and procedures, (where they exist, and for the most part, they don't) are open to individual interpretation. Clients indicated that this has frequently resulted in being treated on a continuum ranging from understanding, flexibility and empathy to disrespect, hostility and exclusion.

2.   Staff employed by the local authority and other accommodation providers were not employed to deliver on a social inclusion agenda. Their brief is generally that of service delivery. Yet, these staff are expected to deliver on a social inclusion agenda in the absence of dedicated training on the issue.

3.   There is insufficient communication between the different agencies who respond to the needs of clients. One of the consequences of this is that clients are not made aware of the range of services and supports which are available to them and problems are frequently addressed in a piecemeal way. This adds to the stress of being homeless and a drug user, which in turn can lead to increased drug use. The absence of formal, effective ongoing communication between, and integration of, services, results in an inability to implement a holistic approach to clients' situations. Another consequence is that much agency time is consumed with receiving the same information from the same clients.

4.   The way in which people are removed from the South Dublin County Council (SDCC) homeless register is problematic. For instance, people are removed from lists if they are imprisoned or if letters are sent out to people and they have moved and are not in a position to respond. The chaotic nature of the lifestyles of homeless drug users is such that they do not often stay in the same place for very long and can be difficult to contact. Clearly in these situations the accommodation needs of individuals have not been met and frequently individuals are not even aware that they have been removed from the register.

5.   Also with regard to the SDCC Homeless Register, at present 'c/o' addresses are not acceptable for applicants. This is clearly in direct conflict with the circumstances of the individual the register is intended to serve and compounds the difficulties faced by homeless drug users trying to get out of the emergency accommodation system.

6.   There are also inconsistencies in how records are kept, what happens to records and who has access to them. This creates difficulties with monitoring service delivery. Consistency in this area would assist in determining the extent of the problems, and working out realistic solutions.

7.   There is an inadequate range and insufficient amount of emergency accommodation options. There have been cases where couples have been forced to split up to access emergency accommodation. It does not accommodate the needs of children and families. Families are often accommodated in one room. If one member of the family is an active drug user s/he has no space to store takeaway methadone safely or take drugs away from other family members/children.

8.   The current nature and range of accommodation for people who are homeless drug users is not only inadequate; it can exacerbate the problem. The majority of service users referred to increased drug use when homeless. They also expressed a preference for rough sleeping rather than use the hostels because of the prevalence of a drug culture within the emergency accommodation system. They also indicated that hostels are unsafe.

9. When drug users try to access emergency accommodation they report being treated differently to non-drug users, in a way which is detrimental to their well-being and the type of accommodation they are offered. Drug users who enter the emergency accommodation system located in the city centre are subsequently not eligible for drugs services in Tallaght as they are no longer living in the catchment area. This compounds difficulties and adds to isolation.

10. Some hostels have intrusive policies (such as demanding urine samples and body searches carried out by security firms) when assessing people who wish to access their services.

11. There is a lack of staff training and supervision within the emergency accommodation system and little or no opportunity for clients to offer feedback on the quality of service they receive.

12. Staff in hostels work long hours in often dangerous circumstances with little support and are frequently untrained in homelessness or drugs.

13. Bed and Breakfast accommodation has grown up in the gap arising from the lack of emergency and hostel accommodation for families who become homeless. Judging by how desirable B&B accommodation is to the respondents of this study, it is as though the private sector has 'crept' into the area of significant provision just by being there. This is cause for concern. Developers can construct accommodation blocks which are fully used for homeless accommodation and homeless people see this as the best option currently available to them. The jump in ERHA spend from £0.6 million in 1997 to £2.2m in 1998 and £4.7m in 1999, on this type of accommodation speaks for itself.

14. There is a reluctance on the part of B&B's to accommodate active drug users so they end up in hostels or rough sleeping.

15. B&B's are being used as a long-term housing option although they are often unsuitable for families.

7.5   Anti-social behaviour and the 1997 Housing (Miscellaneous Provisions) Act

1. The 1997 Housing (Miscellaneous Provisions) Act is problematic. It was introduced at a time when moral panic about drugs was high on the national agenda, and in response to the increase in drug related crime and in drug taking. It is at odds with the social policy direction demonstrated by a Social Inclusion approach, and the move towards harm reduction policies in dealing with drugs.

2. To evict people who are problem drug-users or trying to modify behaviour via punishment of such tenants implies an underlying belief that the answer to a multiple set of socially excluding factors which may result in problematic drug use, is to exclude people still further. This punishment and exclusion model has not worked, and that it should still be driving policy at local level while a conceptual framework for Social Inclusion is being promoted from the Government, highlights a painful blind-spot and a potentially crushing one for those who are involved in the chaotic lifestyles that accompany problematic drug use.

3. Once the label of dealer is attached to a person there is no way back. This is enshrined in the Housing (Miscellaneous Provisions)Act 1997, and further supported by the Tallaght Local Drugs Task Force and SDCC, who fail to address the issue of displacement of 'troublemakers' as problematic in its consequences. There is a whole population of such people drifting around the area, sleeping rough and 'crashing' with friends and relatives. There appears to be insufficient supports in place for the families of those people who end up excluding their family members due to ASB rather than lose the roof over their heads.

    When people are evicted under the Act all other avenues of social housing are also closed to them and they find it difficult to access emergency accommodation. Being re-accepted onto the housing list is very difficult, with requirement on the client that s/he prove that they are no longer a drug user via clean urine samples, and other unspecified means. This is an extremely stressful process to enter with no guarantee of acceptance at its conclusion. A further obstacle is the opposition of local residents to the re-housing of a person who is associated with drugs.

4. The Act is often used on an informal basis (indirect use) which results in people feeling pressured to surrender their tenancy. This is where some of the greatest problems lie. There is no mechanism in SDCC for monitoring or quantifying the number of people who have 'voluntarily' surrendered their tenancies in fear of the threat of the full powers of the Act being used against them. This would result in loss of rent allowance, failure to be considered for re-housing, and being forced into either rough sleeping or emergency hostel accommodation, assuming that they could access this.

5. This whole process remains arbitrary and unaccountable, with no apparent means of tracking its progress.

6. The Act can result in families being 'split up' as it results in the drug user in the family being evicted, or the whole family becoming homeless as a result of 'voluntarily' surrendering their tenancy. Being excluded from eligibility for rent allowance is another likely consequence. This puts drug users seeking to deal with their addiction and living in a council tenancy in a position where they live under fear of detection and the threat that being found out may result in the loss of their homes, and their being 'blacklisted' when seeking re-housing.

7. The implementation of this Act appears to be variable, inconsistent and deviates from the formal procedure as outlined by a senior South Dublin County Council (SDCC) Officer in this study.

8. Housing Officers are effectively expected to assume a policing role in Estate Management with regard to anti-social behaviour. They are placed in the position of having to make judgement calls on whether or not, in the absence of a conviction, the opinion of residents is sufficiently grounded in fact to result in another individual being evicted. It places Housing Officers in an impossible position and tenants suspected of dealing in a vulnerable one.

9. There seems to be an acceptance of the role of residents groups in the context of anti-social behaviour. Is sufficient attention paid to issues around who exactly is being represented? Is there any consideration of recruitment onto groups when they have such a key role in policing their community in relation to anti-social behaviour (ASB) and is there any accountability or monitoring of these groups and their make-up? For instance, what criteria are applied to inform how ASB is addressed? At present there appears to be a community development inspired model but the research findings suggest that the manner in which some groups currently operate leaves them open to accusations of vigilantism.

10. A holistic approach addressing wider issues of poverty and social exclusion is more likely to be successful in the long term rather than moving individuals from one part of the system to another and never actually addressing the underlying contributing factors.

Recommendations in response to each of these issues are outlined in the next chapter.

Chapter 8 – Recommendations

The recommendations of this report are based on the principle that the right to a home is a universal right for all people, including homeless drug users. It is therefore a matter of urgency to address the housing needs of this group.

Arising from the research a number of recommendations have been developed which would help alleviate some of the problems highlighted. Some are general and would need to be adopted by all agencies working in this area and some are specific to particular agencies.

8.1   National level

'They cannot help you with your homelessness because they are there to deal with your habit – and when you are homeless you can't be helped by them.'

'What we would like to do is to provide drug treatment services in homeless hostels, we are hoping to do that…there can be difficulties and resistance, but we're hoping to get at least one off the ground this year.'

'They are all looking for the same money. Even the needle exchanges are fighting. How can they work together when they are all under funded and fighting for the same money?'

1.   Government policy needs to reflect the strong links between problem drug use and homelessness.

2.   There needs to be a clear definition of homelessness asserted by the Government and adopted by all state and voluntary organisations.

3.   Adequate financial and human resources need to be invested.

4.   There is a need for a strategic local approach involving all agencies providing a range of options to facilitate the phased progression of clients, out of drug use and out of homelessness – this needs to include a range of accommodation options including, but not limited to, B&B's and local authority housing.

8.2   Service provision

1.   All staff dealing with homeless drug users should be required to treat their clients with respect and dignity.

2.   All staff dealing with homeless drug users should be adequately trained in relation to both homelessness and drug use.

3.   Agencies with responsibility for working with people who are homeless and/or problem drug users should adopt formal procedures, policies and guidelines for dealing with clients and/or for dealing with typical issues and situations that arise. These should be formally stated and published.

4.   The Social Inclusion Framework, needs to permeate the culture of all organisations with responsibility for operating within this framework. Staff training in understanding the principles and practice of social inclusion should be part of agency commitment to social inclusion. It is unrealistic to expect staff who were recruited in quite a different capacity and within different criteria to deliver on social inclusion principles. Similarly, any new recruitment of staff should reflect the changed context in which staff are expected to operate.

'One of the big things would be an improvement on communications with other service providers. Front-line staff need to sit down together.'

5.   There is a need to develop a mechanism for front line staff in different agencies to meet on a regular basis to share information and to develop an integrated response to clients' needs. This could for instance be a 'case conference' model (the client would also attend).

6. There is a need to develop a more open policy around the sharing of information when it is in the interest of the client and subject to his/her informed consent. Notwithstanding a clients' right to confidentiality there are times when it is clearly not in the interest of the client to have to repeat the same set of circumstances to a number of different agencies.

   '(Homeless people) are form filled to death'

7. Inter-agency and indeed other responses need to involve former drug users in the system. Those who have experienced the issues and are now stable are well placed to work alongside professionals to develop effective, realistic responses.

8. People should not be taken off the Homeless Register without proof that they have been accommodated. The onus should be on the SDCC not the client.

9. The use of c/o addresses for homeless applicants should be permitted.

10. There is a need for consistency in record-keeping within all agencies.

11. Emergency accommodation specifically for homeless drug users needs to be provided.

12. Notwithstanding competing demands for limited resources there should be a greater number of allocations to people on the Homeless Register. Homeless people are one of the most vulnerable groups in society.

   'They look down their noses at you. They think that if they refer us to a nice place we will bring people in and wreck the place.'

13. Codes of conduct for hostels and bed-and-breakfasts should be formulated and published, and should include a statement of the rights and responsibilities of residents and procedures for complaint and redress. Awareness should also be raised among emergency accommodation providers on issues of law and good practice for managing drug-related incidents.

14. A range of services such as drug treatment programmes, counselling and childcare should be made available 'on site' in hostels. Similarly information should be made available to clients on their rights and entitlements.

15. The policy of providing treatment for service users in the catchment area their family live in, should be offered as an option for the first year of those people becoming homeless.

16. More training and supervision should be provided to staff in emergency accommodation. Stricter selection criteria should be applied when hiring staff to ensure sensitivity to the needs of the clients.

17. Information about services available to homeless drug users, including information on service providers, entitlements, procedures, criteria and complaints should be published and made freely available to service users.

18. There should be a clear and effective procedure for making complaints about service provision.

19. The situation whereby drug users lose access to services in Tallaght when they lose their address needs to be amended and this practice to be standardised across all drugs agencies.

20. The privacy of clients should be respected. Space should be allocated in the Homeless Person Unit for individuals to be interviewed in private.

8.4   Anti-social behaviour and the use of the 1997 Housing Act

'They would be afraid no local authority would touch them again if they had been to court and been branded as Anti-Social Behaviour by one authority.'

1. The treatment of 'Anti-Social Behaviour' should be radically rethought.

2. The comprehensive procedure for implementation of the Act as outlined verbally by a senior official in SDCC in the course of the research needs to become a formal written policy subject to consistent interpretation by all Council staff. This should include the exploration of alternative solutions to eviction and provision of alternative accommodation whenever eviction or voluntary surrender takes place. Procedures for dealing with ASB should be formally stated and published.

3. Reflection on the 1997 Act needs to consider the issue of the length of time an exclusion under the Act remains 'live'. There needs to be routes back into the accommodation system for those who have fallen foul of it. Criteria for re-housing of excluded people should be put in place and clear procedures published which take into consideration the challenges of rehabilitation.

4. In addressing the problem of anti-social behaviour, solutions must be sought which do not rely solely on the exclusion of drug dealers, thereby treating all drug dealers as though they are the same. Distinctions must be drawn between degrees of anti-social behaviour. This response should outline a clear distinction between 'dealing' and 'using' and should reach agreement on what is considered to be an acceptable level of dealing to reflect the reality that in any drug culture, small scale dealing is part and parcel of the life of 'using'.

5. There is a contradiction inherent in the 1997 Act. All Government sponsored activity is, according to numerous government initiatives and agreements, to be informed by a social inclusion framework. Local Authority Estates Management Programmes and ASB responsibilities should therefore also operate within this framework. The way in which the Act is implemented is at odds with social policy as it permits, in its indirect application, eviction of one of the most vulnerable groups in society. The current approach to ASB as set out in the Housing (Miscellaneous Provisions) Act 1997 may be understood in a conceptual framework which is far from that of Social Inclusion and Equality.

6. SDCC staff must be required to keep clear records of all instances where they have been in contact with tenants regarding anti-social behaviour, so as to monitor indirect use of the Act.

7. The role of Residents' Associations and representatives in the detection and response to ASB needs to be placed on a clearer and more accountable basis. Vigilantism of any form is of course completely unacceptable but so is a policy of accepting the opinions of residents associations and representatives without any process of verification.

8. Issues such as criteria for and selection of members to residents groups and the scope and power of the group need to be clarified. Structures must be set up which facilitate the inclusion of a range of views, rather than a narrow focus on a particular issue. The process must be managed and monitored, and adequate supports put in place to ensure the group can fulfil its role, including training opportunities in community development practice and principles, tenant participation, consultation and drug use.

9. The encouragement of community led initiatives which allow for the development of new creative models for community consultation and participation should be promoted as part of Estates Management.

10. There is a need to address the issue as intended by the Act. It would be useful to form a time limited 'think tank' comprising all the key players affected by the Act's implementation to develop a coherent alternative or addendum. This should present an effective means of addressing the genuine problems associated with anti-social behaviour but one which in its implementation doesn't inadvertently result in one of the most vulnerable sets of individuals in society being evicted from their homes.

Concluding Comment

Some of the recommendations suggested here are relatively straightforward to implement, others require a longer-term investment and the co-operation of a number of agencies. All require political will. However, political will, resources and development of written policies will be ineffective without attention being paid to the prevailing culture within agencies, and the need for training which will help standardise individual approaches to clients. Small gestures will be ineffective.

Complex issues such as the ones described in this report always require the challenge of creative, flexible solutions – the extent to which agencies with a brief to work with homeless drug users are effective in meeting the long term needs of their clients will be dependent on the extent to which they rise to this challenge.

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