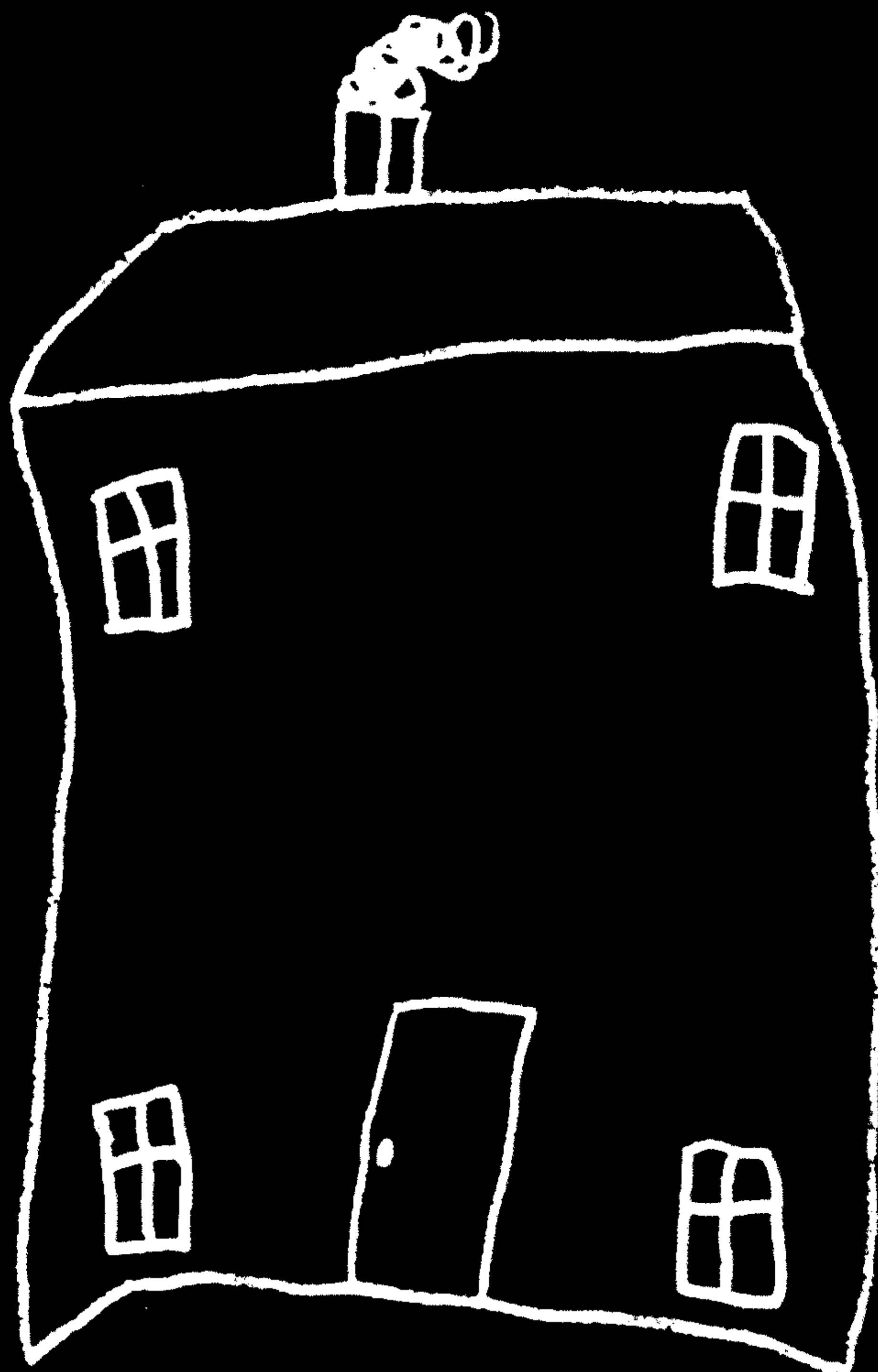
ONE HUNDRED HOMELESS WOMEN

Health status and health service use of homeless women and their children in Dublin



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July 2001

Health Services Research Centre
Department of Psychology
Royal College of Surgeons in Ireland

The Children's Research Centre
Trinity College Dublin

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Preface

Homelessness is a disturbing and growing phenomenon in Ireland as elsewhere. Among the primary concerns for homeless people is health. The term 'homeless' hides the reality of a very heterogeneous set of circumstances and subgroups of individuals. Focused information for service planning needs to be based on information relevant to these groups. This study examined aspects of health of homeless women and their children. Although homeless women constitute a minority of the homeless population, they are a particularly vulnerable group in their own right and, for many, also as mothers. Their needs, and the needs of their children, are an indictment of a society experiencing unprecedented economic prosperity. Their needs pose particular challenges to health service providers and planners.

This study is part of an ongoing series of related studies conducted with homeless people in Dublin. The first of these was a brief 'health census' of the overall population conducted by Holohan in 1998, followed by Feeney et al's study among hostel-dwelling men in 2000. Condon subsequently (2001) added to these self-reported studies by conducting a study incorporating medical and dental health assessments. The present study aimed to provide information on women as a relatively under-researched and invisible group of homeless Irish people to date. A companion piece to the present study is one conducted by Halpenny et al 2001, based on interviews conducted with some of the homeless children whose mothers were interviewed in the study presented here.

The topics addressed include aspects of the life histories and current circumstances of these women as related to their health status and health-related behaviours. Similar information was collected for their children. The overall objective of the study was to provide information for those agencies concerned with planning and provision of services for homeless women and their children.

The project was undertaken by a team from the Royal College of Surgeons in Ireland. Ms Mary Smith RGN SCM is a nurse researcher at the Health Services Research Centre. She has clinical and research expertise including midwifery and women's health, accident & emergency services, methadone maintenance, HIV and hepatitis C. She is currently a Health Research Board, Health Services Research Fellow. Professor Hannah M. McGee, PhD is a health psychologist and director of the Health Services Research Centre, at the Department of Psychology. Her interests are quality of life and quality of care in particular with vulnerable groups. Professor W. Shannon, MD is a general practitioner and chairman of the Department of General Practice. His academic interests include quality of care in inner-city general practice, medical ethics and communication skills of medical students. Dr. Tony Holohan is a specialist in public health medicine, currently Deputy Chief Medical Officer at the Department of Health and Children. His research interests include health effects of homelessness in the Irish setting. His involvement with the project was undertaken while attached to the Eastern Region Health Authority as specialist registrar in public health needs.

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Acknowledgements

We wish to express our thanks above all to the women who responded and gave of their time in difficult circumstances to participate in this research study. Our thanks also the owners and caretakers of the residences involved who provided co-operation and support for the project. Special thanks go to Ms Bernie Melinn, Ms Collette Byrne and the staff at Haven House, Northern Area Health Board (NAHB) hostel, whose guidance and help were invaluable to the project and whose commitment to their work with homeless women was both inspiring and instructive.

Thanks to Mr. Gerry Kenny of the Homeless Persons Unit, NAHB; Ms Liz Pigott-Glynn, Public Health Nurse, NAHB; Ms Mary Higgins of the Homeless Agency; Ms Anne Feeney, Department of Psychology, National University of Ireland, Galway; and the staff at Dublin Simon and Focus Ireland who provided advice and assistance in the planning and conduct of the project.

Thanks also to Mr. Ronan Conroy and Mr. Tony Fitzgerald, Department of Epidemiology and Public Health Medicine for statistical advice. A number of people provided valuable commentary on drafts of the report – thank you for these contributions: Ms Alice O'Flynn, Director of Homeless Services, Eastern Region Health Authority (ERHA); Mr Frank Mills NAHB; and Ms Jean Rafter, Focus Ireland.

Lastly, we thank the Health Research Board whose funding made the study possible and the Northern Area Health Board for funding to publish and distribute the report.

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EXECUTIVE SUMMARY

BACKGROUND

Homelessness is a significant feature of today's urban settings in Ireland as elsewhere. Health problems and difficulties with healthcare access for homeless people are well documented internationally. As a minority among homeless populations, homeless women are often insufficiently represented in studies of homelessness. This study builds on recent work among the Irish homeless and focuses on homeless women and their children in Dublin. Such information is necessary to effectively plan for this vulnerable group.

METHODS

Women availing of emergency accommodation [in bed & breakfasts (B&Bs) and hostels] in the Eastern Region Health Authority (ERHA) area, were the focus of this study. They were contacted through the Homeless Persons Unit (HPU), Northern Area Health Board (NAHB) and invited to participate in a research study about their health and psychological well-being. Lifestyle factors were explored including smoking, alcohol and drug use. Issues of health care access, service use and satisfaction ratings were addressed for both the women and their children. Information regarding routes into homelessness, as well as life-time experience of physical and sexual abuse, were also elicited. Problems with schooling and childcare arrangements were documented. Mothers were asked for permission to interview their older children in detail to provide an understanding of homelessness from the child's perspective. The findings of interviews with twenty-two children of ten mothers are reported separately.

RESULTS

A total of 100 women participated (response rate 38%). Homeless women in Dublin were mostly young mothers, the majority of whom were caring for their children in unsuitable private rented accommodation with low levels of support. They reported significantly higher levels of physical and psychological ill-health than a range of comparison groups. They smoked more but drank less alcohol than their male counterparts and other populations, and had a higher level of managed opiate addiction and higher utilisation of all medical services than comparable others. This was coupled with considerable unmet need in terms of specific treatment services. A history of serious physical and / or sexual abuse was evident for half the sample. The principal results are outlined below.

Demographic characteristics

- The majority of those who participated in the study were young women – less than 35 years of age. Most were single. If married, most had separated.
- Few had completed second level education. The average school leaving age was 15 years with 21% reporting literacy problems.
- The majority were currently unemployed though most had worked or received training – mainly through FÁS (the national training agency) – in the past.
- Eighty percent of the group had a total of 173 children under the age of 18 years.
- Just over one half of the women had some or all of their children living with them – a total of 90 children living with their mothers in emergency accommodation. These children had an average age of 5.6 years with 11% less than 12 months old.
- Average family size was 2.1 children.

Accommodation

- Emergency accommodation is provided by the private sector in B&B's and by private hostels in a ratio of 2:1. This profile was reflected in the study sample with 67% in B&Bs and 33% in hostels.
- Levels of co-operation with the research process varied widely among the accommodation providers - from refusal through to enthusiastic support.
- Much of the accommodation available was deemed unsuitable, particularly for young families. There was often limited access during the day with cramped, unsafe conditions in which many women felt isolated and their children lacked appropriate facilities.

Homelessness

- Most of the women described themselves as temporarily homeless. Inability to find affordable accommodation and domestic violence were the two most commonly reported reasons for entry into homelessness.
- Many women were homeless for more than one year with half the sample having been in their current accommodation for 4-5 months.
- Almost half the sample had 'slept rough', i.e. without a roof over their heads, some time during the previous 5 years.
- Forty-one percent reported being in the care of institutions or persons other than their parents in childhood.

Health related lifestyle

- The prevalence of smoking was 91% compared with 31% of the general female population in Ireland.
- Homeless women drank alcohol less frequently than women in the general population; 'regular' consumption of alcohol (defined in the SLÁN survey having had a drink in the last month) was reported by one quarter of the sample compared to almost three quarters of the general female population.
- For 'regular' drinkers in the sample, their alcohol consumption levels were all within 'safe' limits. A further 25% were non-drinkers and 34% drank very infrequently, 16% reported a problem with alcohol dependency, 7 of whom were 'dry' for periods of 6 weeks to 2 years.

- Almost two-thirds of the women reported ever having used illicit drugs in their lives.
- Almost half were categorised as being addicted to heroin in their lifetime; the majority of these were now in treatment with a further 9% having recently completed a drug detoxification programme.
- Of those having used heroin, 83% reported that they had ever injected themselves with illicit drugs; 33% of these had shared injecting equipment.
- Benzodiazepines were widely abused, by up to 27% of the sample.

Health status

- Eleven percent of the women were registered as disabled.
- Almost half of women perceived their health as good, very good or excellent while the remainder perceived their health as fair or poor.
- Most reported suffering from at least one chronic physical condition. The most common condition was hepatitis C, reported by 25% of the respondents. Most of these reported not being treated for hepatitis C.
- Mental health problems were evident at very high levels with 73% suffering from some form of mental health condition. Depression was the most common complaint with 70% of all respondents reporting depressive illness, almost half of which was untreated.
- Half of respondents had a dental health problem.
- Eleven percent were pregnant at the time of interview; 39% of all mothers had never had a post-natal check-up. Many respondents (43%) had never had a smear test while 21% had never had any form of professional contraceptive advice.

Psychological well-being, social support and quality of life

- One fifth of women reported they did not have a friend or family member they could call on for support if needed; 63% of these were mothers caring for one or more children.
- Using standardised instruments, psychological distress levels were greater than any group with whom comparisons were made, including homeless men.
- Scores indicated psychological distress 5 times greater than Irish norms on one standardised measure.
- Female prisoners were the closest in comparison to homeless women on score levels for another standard measure.
- On the standardised quality of life measure, respondents scored lower than any group for whom comparisons were available, including patients suffering from motor neurone disease and terminal care patients.

Service utilisation

- Fifty-nine percent were registered with a general practitioner (GP) in the Dublin area under the general medical services (GMS) scheme. Ten percent reported being denied GMS cover by their local area Health Board and 5% had had difficulty in being accepted by a GP.
- Two thirds of women had been to a GP at least once in the previous 6 months either for personal health reasons or for their child(ren). Of those having more than one visit, 71% returned to the same GP.

- Those without 'a medical card' (GMS cover for free care) attended GPs less and Accident and Emergency Department (A&E) services more, than those with medical cards.
- Forty-one percent had been to an A&E Department at least once in the previous 6 months for personal health reasons or for their child(ren).
- One third had been to an outpatient clinic at least once in the previous 6 months with 41% having been a hospital in-patient in the previous 12 months. One in three of these were readmitted on at least one other occasion.

Physical violence

- Half the sample reported experiencing serious physical violence in childhood; of these 63% also experienced severe physical abuse as adults.
- In adulthood 55% of the sample had experienced severe physical violence, the majority of whom also reported the experience of physical violence as children.
- Most of the violence occurred in the woman's own home, most was perpetrated by parents in childhood and by partners in adulthood, and most occurred before becoming homeless.
- These homeless women experiencing violence in adulthood were three times more likely to do so than Irish women in general, and five times more likely to sustain injury as a result.
- Most of those experiencing violence in adulthood sought medical attention as a consequence and 13% had availed of specialised refuge services for 'battered' women. More than half had delayed or failed to seek help – the most common reason was fear of retaliation.

Sexual violence

- Half reported experiencing sexual violence (defined as all abusive behaviours involving uninvited and unwanted physical contact of an aggressively sexual nature) in their lifetime. Of these, 63% had been raped on at least one occasion.
- Two thirds of the women reporting sexual violence indicated it began before the age of 15 years with 46% of rape cases occurring before this age.
- The greater proportion of instances of sexually abusive behaviours towards women occurred in their own home and were perpetrated mostly by relatives if in childhood, or a person known to the woman if in adulthood.
- The majority of women reporting sexual violence indicated it occurred, at least in the first instance, before they became homeless.
- For 16%, the sexually violent experience occurred since becoming homeless. One woman was raped by a stranger while homeless and on the street.
- The majority did not disclose the abuse they suffered at the time. Almost one third reported needing and receiving medical attention as a result; 37% needed but did not seek professional (including medical) help; 8% sought but did not receive help.
- The reasons most commonly reported for failure to seek help were that the victim did not know where to look for help - most usually cited if the abuse occurred first in childhood (20%), or fear of retaliation (16%).
- Fourteen women (29% of those reporting sexual violence) said that the experience either directly caused or significantly contributed to their becoming homeless.

- Of the 80 women in the sample with children under age 18, 8 had children whom the mother suspected or knew to have been sexually abused; 7 of these mothers had themselves been sexually abused.

Children

- Eighty percent of the sample had a total of 173 children under the age of 18. Over half of the women had some or all of their children with them – a total of 90 children living with their mothers in emergency accommodation. These children were an average age of 5.6 years, 11% were less than 12 months old.
- Fifty-two children living with their mothers in emergency accommodation were of school going age. Seventeen percent of these attended less than 50% of the time in last school year, while a further 13% did not attend at all. Four children had not been to school in the last 2 years (age ranges 16,14,11 & 9).
- Maternal assessment of children's health indicated that 74% of children living with their mothers enjoyed good to excellent health, although 42% had at least one health problem (28% of these were being treated). Asthma and recurrent head lice were the most common complaints.
- Half of children were reported as having all vaccinations appropriate for their age.
- Five percent of children living with their mothers had an accident requiring hospitalisation.
- Mothers availing of health services for children in their care in the preceding 6 months are as follows: GP services – 60%; A&E services – 29%; attended hospital out-patient services – 20%. Nine children (10%) had been in-patients in the previous 12 months for a stay of 1-14 nights.
- Seven women (9% of mothers) said their children had experienced severe physical abuse, five of these before becoming homeless. Two said their children experienced the abuse as a result of becoming homeless – one in a hostel for homeless people and one by 'carers' in a State-run institution.
- Eight of the 80 mothers knew or strongly suspected that their child(ren) had been sexually abused – two cases were subsequent to their becoming homeless. Six women had become homeless as a consequence of removing their child(ren) from the abusive situation. Thus homelessness may be a consequence of some mothers trying to find a safer place for children than their own homes.

CONCLUSIONS

- Homeless women were mostly young mothers with low levels of educational and skills achievements.
- Drug abuse had been a feature of life for many of these women, the majority of whom had sought and were availing of drug treatment services.
- The very high levels of physical and psychological conditions among these homeless women gives cause for concern, not only because of the impact on the lives of the women themselves, but also because of the effect on the lives of the children in their care.
- Although use of health services appears high, many of the problems and complaints reported by the women remain untreated.
- There was confusion about free (GMS) service entitlement and access.
- The very high levels of physical and sexual abuse experienced by these women increase the challenges to

providing adequate strategies for intervention and care.

- The health and educational needs of the children are compromised by the living conditions of their homeless mothers.

The provision of emergency accommodation through ad hoc arrangements in the private sector is unsatisfactory. The publicly-funded, professionally staffed establishment as provided by the NAHB hostel represented in this study offers a working model on which to base and develop a more appropriate strategy for emergency accommodation needs. Urgent attention is required where levels of distress, particularly for young mothers, constitute a grave risk to the welfare of the women themselves and their children. Service delivery strategies that involve the co-operation of statutory and voluntary agencies require an imaginative and problem solving approach – outreach, fast tracking and opportunistic interventions may be appropriate.

RECOMMENDATIONS

Prevention

- Strategic planning for affordable housing, appropriate to the needs of both families and single people, is essential if the problem of homelessness, both present and future, is to be meaningfully addressed. Plans outlined by the Homeless Agency their new report *Shaping the Future* require urgent implementation and must not be jeopardised by housing shortages more generally. Lack of affordable housing and other factors contributing to poverty in Irish society must be addressed if increasing levels of homelessness are to be avoided.

Accommodation

- The interim situation requires an urgent response from statutory agencies. Publicly funded, accountable and professionally staffed or inspected support accommodation should be made available. The NAHB run hostel provides a working model of how short-term emergency accommodation could be structured. The knowledge and experience of staff in such services can also inform the planning and provision of transitional accommodation. Commitments to the use of B&B establishments in *Shaping the Future*[140] as an emergency and short-term response only, must be honoured.

Service Needs

- The GMS medical card application process for homeless people should be made more accessible. This should involve education of homeless women and staff with whom they have contact, about entitlements and application procedures. Contacts with the health services should be used as opportunities to determine medical card status and to facilitate the application process where appropriate. The 'Action Plan' of the EHRA related to homeless persons, has a brief to provide fast-tracking for GMS application; this must be promoted by all agencies dealing with homeless people.
- The needs of homeless women with psychological disorders require focused consideration of how, where and by whom, services can be effectively delivered. Specialised counselling services for those who have been abused, or have substance abuse problems could provide a fast track route for these women already facing the

difficulties of basic day to-day-living. Consideration should be given to the role of newly appointed counsellors for homeless persons in terms of advocacy for rapid access and 'referring-on' to more specialised services (e.g. physical or sexual abuse, or drugs related counselling) for their clients.

- Strategies for the provision of childcare facilities for homeless mothers should be considered. Support in this essential area would enable them to take up employment, education and training opportunities. This would bring a much needed quality to the lives of mothers who survive on the margins of society in such adverse circumstances. Responses to the needs of children based in emergency accommodation for safe play areas should include consideration of the range of ages to be facilitated. Play groups, mobile 'play-buses', outings etc. should be organised in ways that can be easily accessed by families housed in a number of different locations around the city.
- Peer support and education programmes (by formerly homeless women), similar to the Community Mothers Programme, could be used to inform and support homeless women in accessing services and negotiating health care and service options. Such programmes should be put in place in the short-term, as well as receiving attention for strategic planning where long-term support is necessary.

Service Provision

- Urgent attention should focus on the most extreme cases of distress among mothers in particular with a view to immediate crisis intervention. The new multidisciplinary teams and outreach services for the Homeless Persons Unit, proposed in '*Shaping the Future*', should co-operate in devising strategies for identification and intervention for cases of severe distress and extreme need. Two new ERHA services just started will provide outreach facilities and have a presence in B&B and hostel accommodation . These are a welcome development.
- Outreach services may provide a mechanism through which health screening and promotion could be delivered.
- Opportunistic interventions addressing unmet need for treatment of physical health problems should be promoted among those with whom homeless women have professional contact.
- There is a need to evaluate the role played by drug treatment services in the lives of homeless women. It appears that for many women, access to a GP, to counselling services, to training and educational opportunities and to social worker services are accessed through their drugs treatment centre. Consideration should be given to providing appropriate support or drugs treatment services in their 'extended' role.
- The response to psychiatric services and counselling services is considered in *Shaping the future*. The challenges for a specialised counsellor for homeless persons must include consideration of the role as the access point to services for homeless people. Consideration should be given to their function in 'referring on', if more specialist (e.g. physical and sexual abuse, drug-related) counselling service are required.

Organisational Needs

- There is a need for consultation among health and other professionals who deal with homeless women, addressing the question of how best to structure the required services.
- There is a need to develop links between GPs and other primary care professionals, health boards and

voluntary agencies. The North and South Inner City GP Partnerships, the GP Unit and the Homeless Agency are in a position to facilitate these links, and movement in this direction has commenced This will help to integrate the provision of health services with the other services provided for homeless people, many of which, directly or indirectly, have an impact on health.

- Statutory agencies related to education and child welfare must be included in such consultations. The National Children's Office should co-ordinate strategies relating to homelessness and child welfare.
- New services (envisaged by the EHRA) – the multidisciplinary teams, and planners for the Homeless Persons Unit's outreach services – have the potential to ensure appropriate liaison and service delivery. The EHRA should take responsibility for co-ordinating these services.

Co-operation and Planning

The proposed introduction of co-ordinators for health and care services in each health board area as outlined by the Homeless Agency is both timely and welcome and some staff have already been allocated to these roles. Together with primary care teams (as outlined in the Eastern Health Board report entitled *Homelessness in the Eastern Health Board: Recommendations of a Multidisciplinary Group* (March 1999)), they can provide an important mechanism whereby the previous recommendations can be realised. These teams should at all times act as a support to primary health care services to facilitate the re-introduction of homeless people into mainstream services. Action plans of these teams can be informed by the findings of the present study. The teams should also consider mechanisms for providing a forum for the views of homeless women themselves.

Chapter 1

INTRODUCTION

Health is a basic requirement for independent living and is one of the core aspirations of individuals and nations alike. Many services are provided by the State on behalf of its citizens to promote and maintain health and to manage illness and disability in the population. These services are challenged to provide for people on the basis of need and in ways that are accessible and acceptable to users. In Ireland, the Government's health strategy document "Shaping a Healthier Future"[1] identified equity as one of three underlying principles of their health strategy. Specifically, it identifies disadvantaged groups as requiring particular attention. Homeless individuals clearly constitute one such group.

The number of homeless people internationally has grown consistently since the 1980s.[2,3] Interest in and concern about homelessness has increased in recent years as evidenced by legislative change, funding for research and services and the emerging literature which has been published on the topic.[4-6]

Approaches to defining homelessness

Homelessness is defined in many different ways. While some studies have described homelessness in vague terms[7] which do not allow for easy replication, comparison or generalisation of results, others have simply not defined homelessness.[8] The result is that programming and policy development have often proceeded based on varying assessments of the composition, size and needs of the homeless population.[9] Whether specific or vague, definitions of homelessness usually encompass duration (time) and location (place) of homelessness. The definition of homelessness in terms of these two variables reflects a conceptualisation of homelessness as a continuous variable that can be described by time and place co-ordinates.[9] Homelessness can, therefore, be located at some point along a spectrum of housing need with those without any formal shelter at one end and those who live in shared accommodation but have a clear preference to live separately at the other.[6,10,11] There is no agreement, however, about where upon this spectrum of housing need homelessness should be located and any attempt to place homelessness on this spectrum is necessarily arbitrary and potentially contentious.[6,12]

Legal definitions of homelessness

Homelessness has also been defined in legislation. In the UK, "legally defined" homeless people are often called the "official homeless". The legislation places responsibility on local authorities to help people who meet these criteria, provided they have some "local connection" to the authority's area of responsibility.[10] However, the UK official estimates of homelessness do not include rough sleepers, or those in hostels and bed and breakfasts. These are, therefore, often referred to as the "hidden homeless." [10]

Defining homelessness in Ireland

In Ireland, the Housing Act, 1988[13] sets out the legal definition of homeless persons to include those for whom no accommodation exists which they could be reasonably expected to use or those who could not be expected to remain in existing accommodation and are incapable (due to lack of resources) of providing suitable

accommodation for themselves. O'Sullivan has given due consideration to the issue of defining homelessness in an Irish context.[14] He recommends an approach to the definition of homelessness which takes adequate account of the legislative context and yet provides useful operational definitions for examining needs in this population. It sets out a continuum of homelessness which covers three broad categories (Figure 1.1).

Figure 1.1 Definitions of homelessness in Ireland[14]

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

Under the Housing Act, 1988[13] local authorities are obliged to make periodic assessments of the level of homelessness in their area using guidance from the Department of the Environment. Four such assessments have been carried out between 1989 and 1996. However, these are generally regarded as an unreliable estimate of homelessness and have not been seen to have any practical impact on services to homeless people. Most homeless people in Ireland live in Dublin. O'Sullivan estimated numbers of homeless adults in Ireland at 2501 in 1996; 1776 (71%) of these were located in the former Eastern Health Board region.[15] In 1997, Holohan conducted a survey over a 5-day period of the health status of homeless people in Dublin hostels, bed and breakfast institutions (B&Bs), food centres and on the streets. They identified 792 people of whom 510 (64%) participated in the survey.[16] However, the definition of homelessness which was used in that study was narrower than that used in previous estimates.

In an effort to achieve an accurate profile of homelessness in the Eastern Health Board area, the Homeless Initiative, in conjunction with the Economic and Social Research Institute and homeless service providers, carried out a survey of people who were homeless during the last week of March 1999.[17] People were defined as homeless if they were staying in a hostel, women's refuge, B&B, sleeping rough or staying with friends or family because they had nowhere else to stay. This definition of homelessness is consistent with those recommended by O'Sullivan.[14] The definition excluded asylum seekers. People were included in the survey if they came into contact with any homeless service or were on a local authority homeless list during the week. A unique identifier of initials, date of birth and gender was used to ensure no double counting. Information on duration of homelessness and family circumstances was collected.

The results of this assessment allow for the identification of unmet needs and indicate areas for further research. Such information is useful in itself but will become more so if it is collected consistently over time. It will then be

possible to identify trends in homelessness, assess the effectiveness of services and the effect of policies and other forces on homelessness.

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

This assessment was not intended to provide a comprehensive picture of homelessness and the dynamic of homelessness. To do this would require intensive and extensive research on people who are actually homeless or at risk or potentially homeless. It did, however, provide a baseline of information against which comparisons can be made over time. Most importantly, it provided a definition of homelessness and a methodology for assessing it which has been agreed by those involved in service planning, funding and delivery. A broad message from comparison of the 1996 and 1999 Eastern Health Board survey data was that the problem of homelessness in the region is increasing significantly over time; there is for instance, in the short period of four years, a 63% increase in numbers of people recorded as being homeless. Figures from Focus Ireland[18], a leading homelessness organisation, indicated the number of households on Local Authority Waiting Lists in the year 2000 were 45,645 – up 17% on the previous year ago. The 1999 Homeless Initiative figures estimate 3000-3,5000 homeless people accessing services through the local authorities in the greater Dublin area.[17] 'Rough sleepers', not included in these estimates, are also on the increase up 60% from 3 years ago, and estimated at approximately 200 on any given night.[19] A new government sponsored initiative on homelessness was launched in May 2001. This is a 3 year plan with targets set for structural and service developments outlined in the report titled *'Shaping the Future: an action plan on homelessness in Dublin 2001-2003'*, acknowledges the difficulty in establishing the extent of homelessness and accepts that numbers have increased since the Homeless Initiative figures were compiled.

Women and homelessness

Women are a minority of the homeless population in Dublin, comprising about one third of those accessing services and about one fifth of those 'sleeping rough.[17,19] Despite concerns about the health status of homeless women and children [20,21] actions to maintain or improve the health of homeless families are a challenge [22,23]. They are more likely to use health services than others yet barriers to appropriate and adequate health care have been documented[24]. Barriers relate to the structure of the health system (location/scheduling of services), to attitudes of staff and to aspects of homeless people themselves.[25-28]

Homeless women, with or without dependent children, are a small group but one of the fastest-growing groups of homeless persons.[29] There is evidence of increased physical, psychological and obstetric ill-health among homeless women compared with housed women .[30] Homeless women have additional problems that distinguish them from homeless men and non-homeless women – these have received little attention in research literature. They face a very high risk of physical and sexual attack from intimates, acquaintances and strangers.[31] The lifetime violent victimisation of homeless women is so high a to amount to a normative experience. The majority in one study

were abused as both children and adults.[32] Levels of gynaecological problems are high [33] with pregnancy rates almost twice that of the housed women. This may be associated with limited access to or knowledge about contraception and with sexual abuse. Homeless children of school age who are living in shelters and temporary accommodation have a high level of unmet need for special education evaluations which would allow them to access special education programmes[34] In general, they tend to score poorly on developmental and psychological tests [35,36] and about half are in need of psychiatric evaluation.[37] They are up to four times more likely than other children to have a behavioural disorder. Interventions for such children should consider educational, health and housing requirements.[34] Thus, while homeless women are a relatively small group, the consequences of homelessness for these women appear to be profound, both personally and for the development of their children. Work to improve understanding of and services for this group will help to break the cycle of disadvantage within which these women and children exist.

Homelessness and health

Concern has been expressed about the lack of accurate information for health service planning in homeless populations and its dissemination between relevant agencies.[38] The circumstances of homelessness mean that many agencies cannot readily quantify or characterise the health status of homeless persons. Variability in the findings of many studies of health conducted among homeless groups can be accounted for by methodological differences.[37-41] Research is often limited by the lack of a comparison group to allow examination of disease among homeless people compared to housed people.[42-45] Many samples are prone to (understandable) selection bias and difficulties with generalisation to the larger homeless population not seen in that setting.[46,47] It can be seen, therefore, that there are difficulties in the study of particular diseases or disabilities among the homeless. With these caveats, the available evidence on the health of homeless people, as it relates to the concerns of this study, is summarised next.

Lifestyle and behavioural risk factors

Homeless people are exposed to the same risks for physical illness as the general population but at higher levels, as well as to additional risk factors unique to homelessness.[48] Homelessness may impact on the health of individuals through several aspects of the homeless lifestyle.[37] Some lifestyle issues among the homeless persons such as alcohol and substance abuse may contribute to or cause their health problems. While seen primarily as contributing to the risk of becoming homeless, alcohol or drug use may in some cases be a result of homelessness. Regarding avoiding or reducing health risks, the poor quality and transient nature of many of the settings in which homeless people live means that actions to maintain or improve their health are challenging to all concerned.[49] Furthermore, the disorganised lifestyle that accompanies most homelessness makes adherence to many health recommendations especially challenging.[50] How to avoid or quit smoking in living conditions where it is the norm, for instance.

Smoking

The reported prevalence of cigarette smoking among the homeless population has varied from 23%[51] to 78%.[52] The estimate based on Holohan's study of homeless adults in Dublin was of 78%.[16] The prevalence of smoking in the US has been found to be higher in homeless people when compared with poor housed people.

Alcohol

Alcohol abuse has been cited as the single most prevalent health problem for homeless persons.[53] The estimated prevalence of alcohol abuse among homeless people has varied from 2% to 90% depending on the study design employed.[39] The highest rates seem to be among those drawn from shelters, streets and clinics.[16] Holohan's previous study in Dublin found that 29% of all respondents drank alcohol beyond recommended limits.[16,55] Treatment of alcoholism in this group can succeed with studies showing improved physical, mental, health and social well-being.[56]

Drug misuse

Comparatively little has been written on the subject of homelessness and drug misuse, given the perceived prevalence of these problems in everyday practice.[57] The estimated prevalence of drug misuse among the homeless population has varied from 1% to 70%[39] while the earlier work has shown a lifetime prevalence of 29% among homeless adults in Dublin.[16] Among the homeless in the US, estimated prevalence rates are 10 - 15%[54] although one American study found a lifetime prevalence of drug misuse among the homeless of 52%. It also estimated that the rate of current drug misuse among the homeless population was 8 times higher than the general population.[41]

Environmental conditions

The living conditions of homeless people; either on the streets exposed to trauma, weather and violence, or in hostels which may be overcrowded or have inadequate hygiene, along with factors such as smoking and lack of exercise, all contribute to morbidity and mortality.[47,58] Low temperature is an important cause of morbidity and mortality among the homeless.[47] Homeless people are exposed to the elements even if they are in temporary shelters because they must spend much of their day outdoors.[58] They are, therefore, at risk of sunburn, dehydration, frostbite and hypothermia.[37] Damp environments have also been shown to increase the incidence and severity of chronic respiratory problems.[56] The crowded living conditions of those who reside in shelters and the unsanitary living conditions of those who reside outdoors, may increase the risk of infectious diseases and infestations.[38]

Nutrition

Malnutrition is common among homeless people and may result from limited access to food, poor quality food, alcoholism, drug abuse or psychiatric disorder.[52,58] Various infections may be a complication of, or may be aggravated by, the nutritional status of the homeless person.[60] In many cities, inexpensive meals are available in hostels and day centres and free food is available from soup runs. In spite of this, homeless people still may not be eating well. They may lack the money needed to buy some meals, their irregular lifestyle may make planning of meals difficult and other problems such as alcohol and drug use can work against the maintenance of a healthy diet.[61] Finally, good nutrition may be almost impossible because of poor facilities for storing or cooking food.[62]

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Health problems among the homeless

Health problems that are particularly associated with homelessness include tuberculosis, chronic obstructive airways disease, trauma, foot problems, infestation, epilepsy, peripheral vascular disease, severe psychological disorder and alcohol and drug misuse.[63-65] Their health problems also include common illnesses such as skin problems, functional limitations, seizures, social isolation, visual defects and grossly decayed teeth.[66] The common medical problems of the homeless are magnified by their challenging living conditions.[63] The consequences of such diseases have been found to be greater among homeless adults and children, pointing to the role that homelessness plays as a risk factor for disease and disease complications.

Chronic disease

Chronic conditions are much more prevalent among homeless populations. Between 30% - 40% of homeless people report at least one specific chronic disease[67-69] while 80% to 85% of homeless people report that they have chronic health problems of some kind.[70,71] The management of chronic disease compounded by homelessness is complex and frustrating. Standard textbook recommendations for the management of chronic disease may be unrealistic and impractical in the homeless population and the settings in which they live. The profound disorganisation of the homeless lifestyle militates against even minimal adherence to the simplest medication schedules.[54]

Infectious disease

Since the early part of this century, tuberculosis has been recognised as an important health problem in homeless settings.[71] The prevalence of positive tuberculin skin tests among homeless people is between 18 and 51%[72] while that of active tuberculosis disease is 1.0%[73] to 6.8%.[70] The latter rates are 150 to 300 times the US national average.[74] The positive skin test rate has been shown to increase progressively with the length of time persons spend in shelters or hostels. Unless successfully treated, many go on to infect others in their families, institutions and wider community.[63] Scabies and lice infestation are common in homeless settings and can lead to secondary skin infections.[75] Despite successful treatment, re-infection is likely to occur because of the conditions in which homeless people have to live, e.g. cramped living quarters and the limited access to laundry facilities.[63,75]

Psychiatric disorders

Homeless people with mental health problems experience all the same difficulties that other homeless people meet but have more trouble meeting their needs because of their condition.[76] Those with psychiatric conditions are among the most studied sub-groups of the homeless population. Findings suggest that homeless adults may be more than twice as likely as the general population to have a psychiatric condition. Surveys of homeless people have estimated the prevalence of severe psychiatric disorder at 25-50%[77-79] although estimates have ranged from 2% to 90% for mental health problems in general.[39] Functional psychoses have been most frequently reported while acute distress and personality disorder are also common.[80]

Self-rated health and homelessness

Simple self-ratings of current and functional health status have been recommended to identify homeless people in poorest physical health.[52] Studies have found that 33 to 48% of homeless respondents rated their health as fair or poor compared with 18 to 21% of the general population.[40] In a study of older homeless men, only 18% of them perceived their health as poor, which was somewhat at odds with their recent hospitalisation rates and self-reported physical illnesses.[81] Those among the homeless who are most likely to perceive their health as poor include those with chronic illness, depression and alcoholism.[82] Others with poor perceived health among homeless population include women,[83] early school leavers and those who are long-term unemployed.[68]

Health promotion and disease prevention

Homeless adults require a range of preventive and routine medical services. Providing these services, however, can be challenging for practitioners. Homeless adults may be at risk of a variety of preventable diseases which are often overlooked because of their acute care needs.[84] It has been recommended that the approach to health promotion in the homeless should be multidisciplinary and should reflect both their health needs and their specific housing environments.[85] Simple, preventive health plans could be based upon age, sex, risk factor profiles and conditions commonly encountered.[84]

Primary care

General practitioners (GPs) hold the key to a range of primary health services,[61] and registration with a GP can ensure that a homeless person receives the same quality of service as a housed person.[47] However, the evidence is that homeless people are more likely to use emergency departments rather than primary care facilities for both preventive and illness care.[87] High rates of GP service utilisation[16] and in-patient hospital utilisation[6] have been found amongst the homeless. A primary care clinic study based in homeless hostels, found that the total number of annual consultations was similar to that expected from the general population but that the morbidity patterns seen were different.[46] Those who were in need of regular medication in the study, for example, were more likely to be registered with a GP.[87]

Accident and Emergency services

High utilisation of accident and emergency (A&E) services by homeless groups has been found.[88] The average number of visits per year among a population of homeless persons visiting an A&E department was seven. Alongside high services use however, a high level of dissatisfaction was also found.[88] The relatively high utilisation of A&E services of this group is thought to be due to a combination of higher morbidity and lack of access to primary health care.[88-90]

Hospital services

Homeless people are more likely to be hospitalised but less likely to use out-patient medical services than the general population.[91] Psychiatric illness is over-represented in the homeless population but mental health services are under-utilised in proportion to their needs.[92] Homeless people themselves relate their high rate of readmission to psychiatric hospitals to their lack of resources for survival and they point to the inability of the existing services

to meet their own perceived and expressed needs.[93] Self-reported health is an important predictor of utilisation of services by the homeless in the previous six months. Those reporting chronic medical problems are up to four times more likely to have used out-patient services and eight times more likely to have used in-patient facilities than those who report no medical problems.[70]

Barriers to utilisation of health services

Homeless people face many barriers to health care because of their housing status.[94] The major reasons that homeless people have difficulty in accessing health care can be summarised into three categories: problems with the health care system, the special and competing needs of homeless persons themselves, and the attitudes of health professionals.[95] Figure 1.2.summarises these barriers.[40,73,95]

Figure 1.2 Barriers encountered by homeless people in accessing health care.[40,73,95]

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

These barriers of access to health care mean that homeless people often present late or not at all for health services.[58] Poor adherence to medical recommendations may also affect their ability to receive adequate and effective care.[37] However, the reasons for non-adherence are complex and may reflect an inability to recognise needs in themselves or barriers in access to medical services.[96]

Primary care and preventive services

It has been suggested that the problem in providing primary health services for homeless people lies not in the availability of services, but in their delivery. Some GPs may resist requests for registration with their practice from homeless people while some patients may be unwilling to share the same waiting facilities as homeless people.[43] In the UK, while every citizen has a right to register with a GP, the processes are slow and GPs may be perceived as unhelpful. Reluctant GPs have been cited as the main reason why single homeless people have difficulties in getting access to health care. GPs themselves cite reasons such as the time factor, effects on the other patients in the practice and the "avalanche of need" that might occur should they begin to accept homeless people.[27] Homeless people may also have difficulty gaining access to primary care because they remain on the list of the doctor from their home area.[89] Few incentives exist to encourage GPs to take homeless people onto their patient lists.[97]

Accident and Emergency and other hospital services

Homeless people have been found to be more frequent users of A&E services than others for both illness prevention and illness care.[86] They are also more likely to be hospitalised than the general population. Gate-keeping mechanisms designed to ration care may lead homeless adults to further avoid seeking hospital care in the early stages of illness if the care-seeking process becomes more arduous or time consuming.[48] A recent Canadian intervention found that explicit provision of compassionate care by staff in an A&E department reduced service use by homeless people. There was higher satisfaction with the compassionate care service by homeless attenders.[88]

Health status and health care use of homeless people in Ireland

The first major study of health status and service use of the homeless in Dublin, was completed in 1997.[16] It comprised a brief (10 minute) interview of homeless adults by volunteer interviewers. Interviews were held in hostels, B&Bs premises, food centres and on the streets. All but one Dublin centre permitted researchers to interview; 510 persons were interviewed - a 64% response rate of those invited to participate. Of those interviewed, 15% were women. Most were hostel dwellers (77%), with 6.4% sleeping rough. The study recommended further research and identified areas for service development. Holohan's study provided an important first step in developing information on health needs of homeless people in Dublin.[16] Lack of privacy and time constrained in-depth investigation of topics with those interviewed in this first census-type study. The subsequent report from the Homeless Initiative[17] focused on documenting the size of the homeless problem and the pattern of homelessness. The Homeless Initiative report acknowledged the need for more information from homeless people themselves on their routes into, and patterns of homelessness, and on their physical and psychological well-being and assessment of service provision for them. A study by Feeney, McGee, Holohan, & Shannon (2000)[98] focused in detail on the health status and health care needs and use of the largest constituency of homeless men: those living in hostels in Dublin. One hundred and seventy-one men were interviewed. A further study by Condon et all (2001)[99] aimed to add physical health screening to the self-report information previously obtained. Measures of physical health (e.g. respiratory function) and dental and mental health assessment was conducted for Dublin individuals; 10% of the sample were women. In terms of a logical progression in research among the homeless, the present study aimed to build on the research findings of the Feeney et al study and to act as a companion piece to it by focusing on homeless women. This relatively invisible group, from a research perspective, are also an access point to information about large numbers of children affected by homelessness. This study aimed to interview women in detail with some information collected on their children. A companion study based on interviews with a group of children whose mothers are represented in this study, is reported on separately (Halpenny et al , 2001)[100].

THIS STUDY

The population to be evaluated in this study were homeless women in Dublin, and children in their care, who present themselves to the Homeless Persons Unit of the Northern Area Health Board (NAHB) of the Eastern Regional Health Authority (ERHA). The NAHB has responsibility for directing the provision of emergency accommodation for all homeless women in the EHRA[1]. Those 'sleeping rough' in the city are not included in the study.

Aim

To make evidence-based recommendations for optimal health care of homeless Irish women and their children by documenting the health status and health care access for this group. Key questions for the study include the following:

- what levels of physical and mental health problems are reported?
- what treatment, if any, is availed of for the health problems reported?
- what are the experiences of women in availing of services?
- what are their beliefs, experiences and knowledge of applying for and uptake of free care (via medical cards)?
- what levels of violence or sexual abuse are reported?
- what are the main health status and related issues for children of homeless women?

Specific objectives

- to document the physical and psychological well-being of homeless women availing of State emergency accommodation in Dublin;
- to document their attitudes to and use of health services for their health problems;
- to make comparisons of health and health care access between homeless women and other groups in society;
- to address issues of physical violence and sexual abuse as factors in the lives of homeless women and their children; and
- to propose strategies for optimal management, on the basis of the empirical evidence collected.

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

[1]ERHA provides services to approximately 36% of the population of the Republic of Ireland

Chapter 2

METHODS

Population

The population targeted were women who had presented themselves to the Northern Area Health Board (NAHB) as homeless, and were then provided with emergency accommodation in B&B establishments or hostels for homeless persons. Omitted were those sleeping rough, estimated as a minority of the population of homeless women; approximately 40 women on any given night [16,17,19] during the timeframe of the study.

Procedure

The Homeless Persons Unit, ERHA made available addresses of hostels and of B&B owners providing emergency accommodation for homeless women and their children (and partners in some instances) for the study. The providers of accommodation were asked by letter from the ERHA to allow the researchers access to their residents in order to invite them to participate in a study. Invitation was by letter to named residents, or by general advertisement in hostels and opportunistic recruitment of a group in residence during a given period of time. Prospective participants could indicate their willingness by returning a freepost acceptance form to the project, or by agreeing in person when the researcher visited the establishment. All participants were given full written details of the project. Anonymity was assured, and informed written consent to participate was acquired. The women were offered a token of £10 in consideration of the time taken (interviews lasted on average 1 hour), and were interviewed with due regard for their privacy and willingness to discuss certain topics in varied settings.
While children were not the primary focus of this study, it was felt that the living circumstances of children of women defined as homeless was an integral aspect of the overall domain of concern for many of these women. Some information was sought about children by the Royal College of Surgeons in Ireland (RCSI) team, who also arranged recruitment to phase two of the study; a collaborative project with the Children's Research Centre, Trinity College Dublin (TCD). Families with older children (i.e. those aged 8 years and older) were invited to participate in this phase by agreeing to a children's interview with the TCD team. Where mothers consented to the child interview, they were contacted by a researcher from the Children's Research Centre. The details of these interviews are the subject of a separate report (Halpenny et al, 2001).[100] General details on the children as reported by their mothers are outlined in this report. Interviews were conducted from May to October 2000.
This study was a companion piece to, and built on, the Feeney et al study of homeless men in Dublin[98] conducted in 1999. Many of the measures used were common to both studies; other measures were omitted or modified in this study, and new areas of investigation included. Some sections of the interview were conducted using questionnaires already standardised in the research literature. A brief outline of each of the sections of the questionnaire follows.

- *Basic demographic information*

Basic information on topics such as age, education, employment, marital status, parenthood and location of childcare was recorded.

- *Details regarding homelessness*

A brief description of the circumstances surrounding the respondent's entry into, history and duration of homelessness was sought. This was to supplement information from the Homeless Initiative study on routes into homelessness.

- *Lifestyle and health behaviours*

Participants were asked about smoking and alcohol using a format of previous health surveys such as the SLÁN Survey[101] of health behaviours among the Irish public. This survey included N=6539 adults and was conducted in 1998. In addition, a 12-item measure of alcohol dependence was included which assessed loss of control, symptomatic behaviour and binge drinking. This measure was also used in the OPCS Survey of Psychiatric Morbidity Among Homeless People.[102]

- *Drug dependence*

Participants were asked about misuse of drugs including anti depressants and benzodiazepine use, sedatives, tranquillisers and use of illicit drugs including cannabis, cocaine, opiates, hallucinogens, ecstasy and solvents. These questions were drawn from the OPCS Survey.[102] Lifetime use, current use and drug dependence were established for each drug. Information regarding abuse of prescribed medication was also elicited. Treatment for opiate use and high risk behaviours associated with heroin use were explored.

- *Physical health problems*

Information was gathered on the presence of any chronic illnesses. A 25-item problem checklist was used to record health complaints and treatment accessed.

- *Psychological status*

The 12-item General Health Questionnaire (GHQ-12) was used to provide a general measure of psychological distress.[103] Levels of caseness (% of participants who would be seen as needing help from a mental health professional based on the problems reported) can be identified with this measure. It is therefore possible to identify those whose self-reported problems are sufficiently serious as to warrant mental health services. GHQ-12 has been validated in a study of over 5000 community participants as being as sensitive as longer measures in screening for psychiatric morbidity.[104] It has been used as the measure of distress for homeless participants in the recent first National Psychiatric Morbidity Survey of Great Britain.[102] Thus, possibilities for general population and other homeless group comparisons are available. It was not possible in the present setting to have a clinical assessment of psychological status. Because of this, and because of self-selection of participants into the study, it is certainly the case that some serious and more psychotic types of psychological disorders would not be recorded here. Thus levels of psychological problems recorded in the study will necessarily underestimate prevalence in this group.

- *Use of health services*

Participants were asked about their perceived health care needs, contact with health services for themselves and children in their care and any difficulties they perceived in accessing health care in the previous 6 months. The

interview combined question formats from the National Psychiatric Morbidity Survey of Great Britain,[102] Holohan's Dublin survey,[16] and Feeney et al's recent study among homeless men[98], in order to maximise the comparability of data and identification of common and unique features of homeless women in Dublin and other homeless populations. The topics covered were: medical card ownership; frequency of attending GP, A&E, outpatient and other health services in the previous 6 months; reasons for accessing these services and satisfaction ratings and problems encountered with most recent visit. The schedule also included aspects of gynaecological and obstetric health and use of in-patient services for adults and children.

- *Self-assessed health status*

Self-assessed health status was recorded by use of the SF-12 [105] which has two component parts assessing physical and mental health. It is an abbreviated form of the more widely used SF-36 and allows basic comparison with Irish population norms[106,107].

- *Quality of life*

General quality of life was measured by using the short-form Schedule for the Evaluation of Individual Quality of Life (SEIQoL-DW)[108]. SEIQoL-DW assesses quality of life from the perspective of the person being interviewed. Thus individuals name the 5 areas most important to their quality of life, describe current functioning in each of these areas and outline the relative weighting or importance they give to each area in their judgement of quality of life. This information is combined into a single score from 0.0 – 100.0 with higher scores representing better quality of life.

- *Social support available*

Selected questions from The MOS Social Support Survey[109] were included in the schedule as a measure of four categories of social support. This measure assesses four dimensions of support: tangible support; affectionate support; emotional and informational support, and positive social interaction support. It also contains one structural support item which asks about the number of close relatives and friends available to provide support. The questions selected are representative of the four dimensions, but comparisons are limited by the truncated form in which the measure is used. Some comparisons with homeless men in the Feeney et al study were possible using this method.

- *Physical and sexual violence*

The international literature suggests that the lifetime violent victimisation of homeless women is so high as to amount to a normative experience.[32] The schedule therefore addressed the issues of domestic and sexual violence experienced by homeless women and their children. The questions used are a composite of questions and adaptations of schedules used by other sourcess addressing these issues [110,111] and questions formulated by the research team. Because of the sensitive nature of the topic, the women were re-reminded of their option not to answer questions or to provide details only to the extent to which they felt comfortable, before this section was addressed.

- *Children*

Information was sought about children; numbers, ages and health issues, schooling and accommodation profiles. The issue of physical and sexual abuse of children (known or suspected) was also addressed. Mothers were first informed of the responsibility of the researcher to report instances of children identified as at risk and not already known to the authorities, and were reminded that they were supplying information that they deemed appropriate to disclose.

Ethical considerations

In planning the study, a number of strategies were adopted to protect the well-being of the research participants and researcher and to protect confidentiality. While all participants, by definition, were living in difficult personal circumstances, there may be occasions in studies such as this where the researcher perceives the individual to have serious acute difficulties - either psychological or physical. In these circumstances where it would be considered unethical not to act, the interviewer was in a position to provide appropriate assistance. For instance, in the circumstance of acute health care needs, details of emergency service access or GP availability would be given. For other queries, an agreed contact number in an agency dealing with the required service would be provided. The section of the interview relating to sexual violence was prefaced with a repeat of the clarification to women that they could participate or not as they felt appropriate. Women with children were advised that if they disclosed specific cases of children at risk, researchers would feel obligated to report this to the appropriate agencies if it had not been previously reported.

Well-being of researcher

A protocol to ensure interviewer safety was established. The researcher carried a mobile phone for security and left instructions regarding her whereabouts with colleagues when travelling to and from interviews. Counselling services could also be paid for and availed of by the researcher if the intensive nature of the work created difficulties. It is important to emphasise that all of the above constitutes good research practice in otherwise unsupervised research settings rather than a fear of unique dangers in conducting research with homeless people.

Confidentiality of information

Completed interview forms did not have participant identifiers such as names. These forms were stored securely and no data identifying participants was stored electronically. The study was approved by the Research Ethics Committee, RCSI prior to commencement.

Chapter 3

RESULTS I: Demographic and accommodation profile

Recruitment

The Homeless Persons Unit of the ERHA estimated that emergency accommodation available to homeless women was in a ratio of 2:1, bed and breakfast establishments (B&Bs) to hostels. The study sought to recruit women from B&Bs and hostels in these proportions to reflect the population profile.

B&B accommodation

Lists as provided by EHRA's Homeless Persons Unit identified 39 B&B establishments. Owners of 33 B&Bs indicated they accommodated homeless women at the time of the study. Six owners controlled multiple (2-4) establishments with others having one establishment each. Following introductory study letters from the Homeless Persons Unit, one owner refused and the remainder agreed to co-operate with recruitment (i.e. provided names, allowed access or offered to distribute recruitment literature). The level of co-operation varied widely. Some provided high levels of co-operation; making a room available for interviews, allowing access by the researcher to communal gatherings of the residents (breakfast time, for example) where the project could be explained, and generally providing approval for caretaker / security staff to facilitate the study. The co-operation of caretakers and / or security staff with the researcher was essential to the study and recruitment was generally high where the optimum level of co-operation was achieved. Recruitment strategies were made more difficult to implement where B&B owners were reluctant in their responses. Some were slow to respond to repeated written and telephone efforts to contact them; or to provide accurate, or in some instances any, information on the number of residents and accommodation units. Some (N=3) refused to allow the researcher access to their premises. There was anecdotal evidence of failure to deliver recruitment material posted to named residents or left with care-taking staff for distribution. Numbers of residents accommodated in any single establishment varied between two and twenty. Of 32 establishments participating in recruitment, three yielded zero responses from among the residents. The remaining 29 produced response rates that varied from 10% to 75%.

Invitations were issued to 267 residents of B&Bs. A total of 67 were interviewed. A further 25 women responded to the invitation to participate with 4 refusing, 16 agreeing but failing to show up or be interviewed for various reasons and 5 responding too late to fit within the time-frame of the study. Those who failed to show or postponed an agreed interview were contacted, sometimes repeatedly, to reschedule. Overall a response rate of 26% was achieved[1].

Hostel accommodation

The main hostels providing accommodation for the population of interest were asked for their co-operation by letter from the Homeless Persons Unit. Thus 4 hostels were targeted; one privately owned and run, one ERHA operated and two run by religious organisations, one of whom receives partial government funding. Three agreed to participate by providing names, allowing access or offering to distribute recruitment literature (these had a

Note: As the date set for closing recruitment approached, 96 women had been interviewed. The numbers achieved reflect the 2:1 distribution estimated by the Homeless Persons Unit of B&B to hostel dwellers.

combined capacity of about 60 beds). One religious hostel, which had the largest capacity of about 100 beds, did not participate. As with the B&B residents, potential participants indicated their willingness by responding to the recruitment literature by freepost (which had been addressed to named residents or left with hostel staff for distribution). Hostel residents were also recruited by agreeing in person to interview on the day, on an opportunistic basis. Again, where the co-operation of those in authority was forthcoming, recruitment was highest. A total of 33 women were interviewed – a response rate of about 50% of the residents at the time.
The interview schedule was piloted in the EHRA hostel. The advice and information provided by the staff, as well as their level of co-operation with subsequent recruitment among the residents, was invaluable to the study. Respondents from other hostel and B&B accommodation were contacted and arrangements made to interview them where convenient. Residents who were not allowed visitors or had time-limited access to their room or place of residence were interviewed in a variety of settings nominated by them. This was usually a local café or public park. Two women availed of the option to be interviewed in the researcher's office.

Demographic profile

The majority of women who participated in the study were young, with almost three quarters in the 18-34 year age group (Table 3.1). Thirteen respondents had completed second level education with one having completed third level. The average school leaving age was 15 years – 35% had left school before then. Two women had had skilled employment, twelve women had worked in unskilled jobs, 43 had never had any job or training, the remainder had had training but no employment as a result – mostly through FÁS (Foras Áiseanna Saothair – the national training and employment authority) schemes. Among these were ten women who had also availed of special courses through drug treatment services, disability groups or other agencies. Three women were working part-time and a further five were on a Continuing Employment (CE) scheme. The remainder were unemployed. Most of those who had availed of life skills, adult education or special courses through drug treatment services voiced unsolicited and enthusiastic endorsement and appreciation of same. A majority of the women (N=79) reported no literacy problems, nine reported slight problems, nine others significant problems and three more were entirely illiterate. The majority of the women (N=68) identified themselves as single. Of those who had married, most had either separated or were divorced from their husbands. Five women reported that they were married while ten described themselves as 'living with a partner'. Eighty-two of the women had children, 80 of whom have a total of 173 children under age 18 years (94 females, 79 males); mean age of these children was 6.8 years (SD 4.6; range 2 months to 17 years). Family size was a mean of 2.1 children (SD 1.2; range 1-7). Fifty-five women had some or all of their children with them. The majority of participants in this study were Irish (N=98); one was from the UK; one was another European Union (EU) national.

Table 3.1 is the first in a series of comparisons between the sample of homeless women in the study (N=100) with the sample of homeless men (N=171) in the 'companion' study by Feeney et al [98]. Women were typically younger.

Table 3.1 Demographic profile of homeless women compared with homeless men in Dublin

		Women (N=100) %	Men (N=171) %
Age	18-34 years	74	26
	35-54 years	22	53
	55+ years	3	21
	< 18 years	1	-
Education	Primary school only	56	55
	Junior second level	29	15
	Completed second level	13	13
	Third level education	1	17
	Special school	1	-
Marital status	Single	68	59
	Married/living with partner	5+10	5
	Separated/divorced	14	32
	Widowed	3	4
Parenthood	Having 1 child	29	27
	Having >1 child	53	73
	1 child < 18 years	31	45
	Having > 1 child (under 18 years)	49	55

Homelessness profile

It was of interest to see whether respondents viewed themselves as homeless; they were first asked to describe their view of their current accommodation status. As outlined in Table 3.2, 98% saw themselves as homeless, the majority of whom (58%) saw this condition as temporary. They are similar to homeless men in the Feeney et al study.

Duration of homelessness

For 61 of the women this was their first experience of homelessness. A substantial minority of these (n = 25; 41%) had been homeless for less than a year in total (Table 3.3). The table also compares the duration of the current episode of homelessness of with homeless men in the Feeney et al study.

Table 3.2 Self-defined accommodation status of sample homeless women compared with homeless men

"Would you describe yourself as homeless?"		Women %	Men %
No:	I have a home here	2	3
Yes:	Temporarily	57	53
	Semi-permanently	22	12
	Permanently	19	17
Other		-	16

Table 3.3 Duration of current episode of homelessness of women (F) with homeless men (M)

	Total Sample %		Those whowere previously homeless %		Those who were not previously homeless %	
	F	M	F	M	F	M
	(N=100)	(N=169)	(N39)	(N=66)	(N=61)	(N103)
Less than 6 months	20	33	26	50	16	22
6 months or more, less than 1 yr	26	14	28	13	25	13
1 yr or more, less than 5 yrs	48	35	31	21	59	44
5 yrs or more, less than 10 yrs	6	9	15	8	0	11
10 yrs or more	-	9	-	8	-	10

The median duration of the current episode of female homelessness was 72 weeks (mean = 88 weeks; range: 2 weeks to 6 years) compared with 52 weeks for the men (mean = 182 weeks; range: 1 week to 45 years). Long-term homelessness was defined, for the purposes of further analysis in this study, as the current period of homelessness being of one year or longer in duration. Thus 54 of the women were defined as long-term homeless; similar to the profile for homeless men.

Length of stay in current accommodation

In this current period of homelessness, the women had spent between one day and 2 years in the hostel or B&B where they were interviewed. On average, the women who had been homeless for less than a year had spent a median of eighteen weeks in their current residence (mean 18; SD 13.6), while the women who are identified as being long-term homeless had spent a median of 16 weeks in their current residence (mean=24; SD 25.5) (Table 3.4). Some of the women were recent arrivals: 16 women had spent less than a month in their accommodation; 72 had spent between one and eleven months there and twelve had been there for one to two years.

Table 3.4 Length of time in current emergency accommodation for homeless women

	Entire sample	Short-term homeless		Long-term homeless	
	N	N	%	N	%
Less than 1 month	16	6	13	10	19
1 to 11 months	77	40	87	37	68
1 yr or more, less than 5 yrs	7	-	-	7	13
5 yrs or more	0	-	-	0	-
TOTAL	100	46	100	54	100
Median no. of weeks	16	18		16	
Mean (SD)	21(21)	17.9 (13.6)		23.8 (25.6)	

Accommodation

A number of different types of accommodation had been used by the women over the previous five years and during the previous seven nights – as outlined below (Table 3.5).

Table 3.5 Types of accommodation used by homeless women in previous 5 year period and previous 7 night period compared with use among homeless females in Counted In study[17]. Values for homeless men provided in brackets (%)

Accommodation types used in previous 5 years[a]	Sample % (%mean)	Accommodation type used in previous 7 nights[b]	Sample %	Counted In % (%men)
B&B	87 (0)	Bed & Breakfast	68	10 (3)
Hostel	61 (100)	Hostel	32	53 (61)
Friend	48 (28)	Friend	1	7 (9)
Street/sleep rough	47 (25)	Sleep rough/street	1	14 (21)
Family home	45 (29)	Other	1	6 (4)
Local Authority housing	29 (16)			
Private rented housing	28 (0)			
Squatted housing	23 (2)			
Prison	22 (8)			
Hospital	20 (5)			
Lived abroad	18 (9)			
Health board provided	9 (5)			
Rehabilitation centre	4 (4)			

[a]Compared with 171 homeless hostel dwelling men; [b]Compared with 1050 homeless females in Counted In[17] study

Reasons for becoming homeless

Respondents were invited through open questioning in the initial stages of the interview to identify the 'main reason' they had become homeless in the first place. Some answered in terms of the events that precipitated their entry into homelessness, others answered in terms of what they perceived as underlying causes for their state. Some provided straightforward answers, others identified a range of complex and interacting factors, and some revised their responses in light of information provided later in the interview. For instance, one woman who initially stated that she became homeless because she "did not get on with the family" later indicated that the sexual abuse of her children by her father, with whom she shared the family home, was her reason for leaving that home and thereby rendering herself homeless. Table 3.6 outlines the reasons for becoming homeless as identified by the women and categorised into 13 domains. Failure to find affordable accommodation, the most common reason for becoming homeless, is almost equally divided between those who had been in accommodation and had been faced with unaffordable increases in rent and/or given notice to quit (or, in some instances, illegally evicted) by the landlord, and those who were coming into the housing market for the first time (e.g. returned emigrants, young families needing housing).

Eviction for anti-social behaviour had impacted on families, displacing mothers with children because of the activities of other household members. In one instance, a family of 6 had been evicted from their home of 30 years because of the drug-dealing behaviour of the adult sons, now resident in the UK.

Table 3.6 Reasons for homelessness as identified by homeless women

Reason	N
Failure to find affordable accommodation	18
Domestic (physical) violence	14
Family problems (complex, and/or unspecified)	13
Addiction problems	11
Multiple and complex reasons ; 'other' ; no reason offered	10
Overcrowding in family home	8
Eviction (3 for rent arrears, 4 for anti social behaviour)	7
Psychological disorder	5
Thrown out of family home (because of pregnancy 3 cases)	4
Bullied / harassed in neighbourhood	4
Sexual abuse of children	6
Problems with standard of previous accommodation (e.g. vermin infestation)	3

Experience of being 'in care' during childhood

Early life experiences have been associated with vulnerability in adulthood, including vulnerability to homelessness.[91] Forty-one of the women reported being reared in settings or spending time in other than the care of their parent(s) before the age of 18. Table 3.7 outlines these experiences; locations are not mutually exclusive.

Table 3.7 Accommodation / home experiences of homeless women before the age of 18 years

Type of accommodation	N
Foster care	11
Lived on the streets	10
Lived in homeless accommodation	9
Reared by different relatives / extended family	9
'In care'	8
In youth detention	9
Squatted housing	7
'Out of hours services'- (health board provided emergency accommodation)	3
Special needs boarding school	3
Long -term hospital care	1

In summary, these women were mostly poor, young, mothers, homeless for more than a year whose economic, educational and social background increased their vulnerability to homelessness.

Chapter 4

RESULTS II: Health Behaviours

Health related lifestyle

Respondents were asked a number of questions on various aspects of their lifestyle related to smoking, alcohol and drug use. Comparisons were made with Irish data from SLÁN, the National Health and Lifestyle Survey[101] and with UK data from The OPCS Survey of Psychiatric Morbidity Among Homeless People[102]. Due to differences in data gathering and presentation, comparisons with the OPCS findings are limited. The type of accommodation provided in the UK for the homeless is used to categorise or classify the population of interest. The group that most compares with the B&B dwellers in Ireland are those in the Private Sector Leased Accommodation (PSLA) classification of homeless persons in the OPCS survey. PSLA caters mostly for families or lone parents with children. Of adults accommodated in PSLA, 63% are women; hostel dwellers in the OPCS survey are 30% women.

Smoking

The prevalence of smoking was 91% of respondents identifying themselves as regular smokers compared with 31% of the general female population[101] (Figure 4.1).

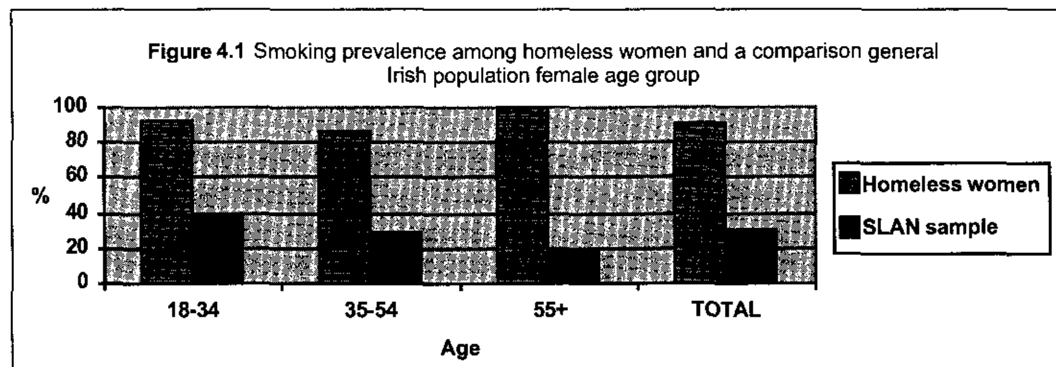


Figure 4.1 Smoking prevalence among homeless women and a comparison general Irish population female age group

The average number of cigarettes smoked daily was 24 (SD: 14.3). Thirty percent smoked less than 20 cigarettes daily, 53 % smoked between 20 and 40 cigarettes a day and 17% smoked more than 40 cigarettes a day. Of current smokers, efforts to or intentions to quit were low, as detailed in Table 4.1

Table 4.1 Previous efforts and future intentions of current smokers to quit among homeless women

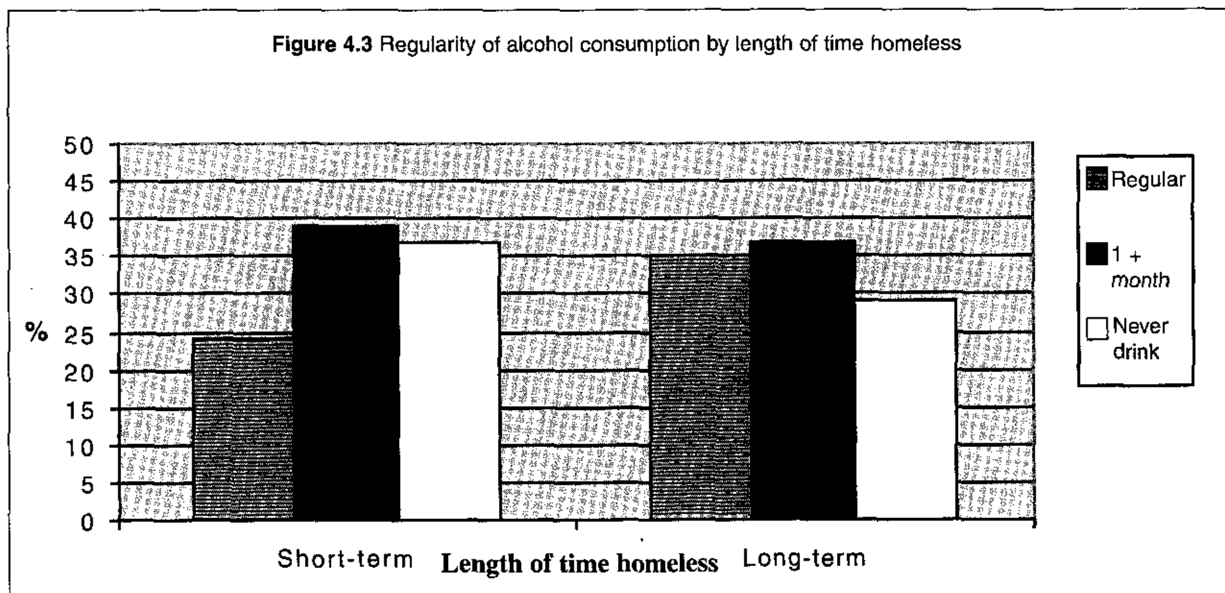
		N
"Have you ever tried to stop smoking?"	Never	46
	Yes, but not in past 2 years	28
	Yes, in past 2 years	17
"In the future, would you like to ..."	Carry on smoking	31
	Stop smoking in next 12 months	2
	Stop smoking at some point in the future	57

The interview schedule made provision for qualitative data gathering by recording comments that respondents wished to make, either in response to open questions, or spontaneously. Many of the women acknowledged they "smoked too much" or that the "fags were killing them", but some also made the point that it was virtually the only social outlet they had to sit in a café or public place and "have a smoke" with a friend or another of the residents in the B&B. For women with children, some regarded smoking as an affordable alternative to eating properly. One women said "If you can't cook at home you have to rely on burgers for the kids and its very dear on what we get. I'd have a cup of tea and a smoke instead, it's cheaper – let the kids have the food".

Alcohol Use

Twenty-five respondents reported that they were non-drinkers and 38 said they very seldom drank. A minority of the group (37%) were categorised as regular drinkers [Regular drinking is defined by SLÁN as having consumed alcohol in the previous month.].This is low when compared to the figure of 71% of women from the general Irish population[101] and to 46% of those in the PSLA category of homeless persons in the OPCS.[102] In terms of frequency of consumption and quantity consumed, regular drinkers (who were not alcohol dependant) imbibed an average of 1.4 days per week and consumed an average of 12 units per week. Sixteen percent of respondents were alcohol dependant (compared with 5% of the PSLA persons in the OPCS survey), 15 of whom were severely so, according to the criteria adopted by the OPCS survey Seven (44%) of the alcohol dependant women in the sample reported they were currently 'dry' for a period of between 6 weeks and 2 years. Figures 4.2 illustrates regularity of alcohol consumption by age. There was no association between age and length of time homeless and regularity of alcohol consumption.

Figure 4.3 Regularity of alcohol consumption by length of time homeless



Of those who had a drink in the last month, 22% reported that they typically consumed alcohol every week. Four percent of women reported that they drank alcohol on five or more days in the week. This compared with 9% of

women who participated in the SLÁN survey. One woman said she drank as much and as often as she could afford. There was no relationship between age group or length of time homeless with the number of days per week during which alcohol was typically consumed.

Table 4.2 Number of days drinking by regular drinkers in typical week by age and duration of homelessness among homeless women and a comparison group

	Homeless women (N=22) %			**SLÁN: female sample (N = 3,528) %**		
	1-2 days	**3-4 days**	**5+ days**	**1-2 days**	**3-4 days**	**5+ days**
TOTAL	77	14	9	68	24	9
Age						
18-34 yrs	73	20	7	71	25	4
35-54 yrs	86	0	14	68	23	9
55+	0	0	0	51	23	26
Length of time homeless						
Short-term	76	12	12	-	-	-
Long-term	79	14	7	-	-	-

Drug misuse

Respondents were asked to report on previous and current drug-taking behaviour. Almost two thirds of the women (64%) reported illicit drug use at sometime in their lives. Illicit drug use was most prevalent among the younger women (though the difference was not statistically significant); 83% of the 18-34 year olds reported any lifetime use of an illicit drug while the figure was 16% for the 35-54 year olds. Similar to the comparison group in the OPCS and the Feeney et al study of homeless men in Dublin, the main illicit drug used by homeless women was cannabis (41%). Lifetime and current use and abuse of drugs is outlined in (Table 4.3), including prescribed drugs which were abused. It compares, where possible, information for homeless women with the sample of homeless men. There was a high level of heroin addiction among the women, most of whom are on a treatment programme of methadone (heroin substitute) maintenance. Heroin addiction and associated risk behaviours are outlined in Table 4.4. Homeless women abused drugs to a greater extent than homeless men, in particular anti-depressants, tranquillisers, benzodiazepines and sleeping tablets. Current use was defined as use of a drug in the previous 12 months. More than one third of respondents (41%) reported having engaged in illicit use of at least one drug in the previous year – with cannabis the most frequently used illicit drug. This compared with 7% among the comparison OPCS group. The European Monitoring Centre for Drugs and Drug Addiction[112] reported figures ranging from one to nine percent for current use of cannabis in European countries. Homeless women were more likely to have used anti-depressants, benzodiazepines, methadone, heroin, sleeping tablets and ecstasy than homeless men.

Table 4.3 Drug abuse by homeless women (N=100) compared with homeless men (N=171)

	Lifetime use %		Currently abusing %		Currently prescribed %	
Drug Type	**Homeless women**	**Homeless men**	**Homeless women**	**Homeless men**	**Homeless women**	**Homeless men**
Anti-depressants	54	10***	12	u/k	44***	10
Tranquillisers/ benzodiazapines	52	20***	25	12**	23	15
Methadone	48	u/k	1	u/k	45	3
Heroin	47	18***	30	11	-	-
Sleeping tablets	45	19***	27	14*	35	19**
Cannabis	44	51	41	30	-	-
Ecstasy	36	20***	12	9	-	-
Psychedelics	22	28	5	4	-	-
Cocaine	21	20	9	9	-	-
Other opiates	21	15	8	4	-	-
Solvents	10	15	0	2	-	-

u/k = unknown   Female::male comparisons: * $p<0.05$ ** $p<0.01$ *** $p<0.005$

Drug dependence and treatment

According to criteria outlined in the OPCS study, respondents were classified as being dependent on a drug if they had taken it every day for two weeks or more in the previous 12 months[102]. Almost 45% of respondents were categorised as being drug dependant, compared with 11% of hostel-dwellers and 7% of PSLA residents in the OPCS survey. All of these women (N=45) were opiate dependant (former heroin addicts) though all but one was involved in a treatment programme. Four had recently completed a programme of opiate detoxification (detox); five were currently on a detox programme; 35 were on methadone maintenance; one woman was using street physeptone (heroin substitute) – she had been waiting 3 months to access a state-provided programme through the drug treatment services. Those receiving methadone treatment had been doing so for a median of 16 months on their current programme with a median lifetime use of methadone of 3 years. Prescribed medications - anti depressants and benzodiazepines were commonly abused both by those for whom they were prescribed and otherwise. Of those for whom anti-depressants were prescribed, 20 % abused the prescribed dose (abused meaning took more of the medication than they should); 32% of those prescribed sleeping tablets abused them and 39% of those prescribed other benzodiezapines (mostly valium) abused them.

Heroin use and risk behaviour

Heroin use and associated risk behaviour is outlined in Table 4.4. and compared with similar data for homeless men. The women report significantly higher levels of some risk behaviours, though differences in the numbers who have 'ever shared' injecting equipment do not reach statistical significance. The figures are higher than the corresponding figures from the OPCS study[102]. The UK study reported that 8% of respondents had injected themselves with drugs in the past, while 2% had shared injection equipment.

Table 4.4. Heroin use & associated high risk behaviours; gender based comparisons between homeless persons

	Homeless women (N=100) %	Homeless men (N=171) %
Ever used heroin	47	54
Ever injected	39	12*
Injected in past 12 months	22	5*
Ever shared needles	13	8
Shared in past 12 months	13	2*

* P < 0.005.

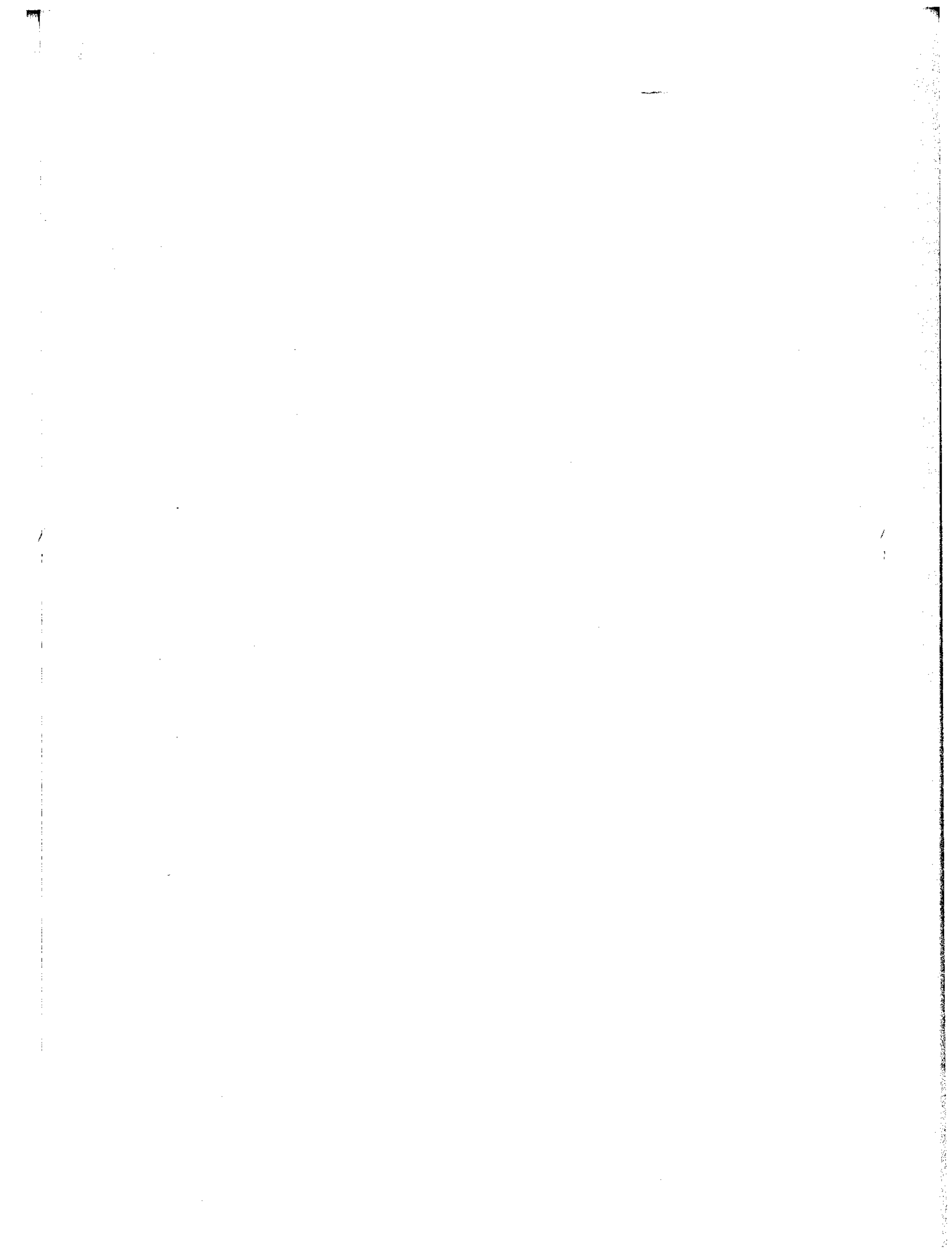
Table 4.5 makes some comparisons between homeless Irish women in the sample, homeless English women in the OPCS survey and Irish hostel dwelling men from the Feeney et al study, with emphasis on lifestyle factors. Demographic details are included to illustrate the comparability of the Irish B&B and the English PSLA residents. Physical & mental health factors are included but are discussed in greater detail later below.

Table 4.5. Homeless persons by sex and accommodation type and demographic, lifestyle and health factors

	Irish B&B dwelling women (N: 67) %	Irish hostel dwelling women (N: 33) %	English PSLA dwellers (63% are women) (N: 268) %	English hostel dwellers (30% are women (N: 530) %	Irish hostel dwelling men (N: 171) %
Under age 35 years	68	32	72	61	26
Have children in their care	51	4	67	17	0
Alcohol dependant	10	27	5	25	50
Opiate addicted	37	67	2	3*	6
Tobacco smoker	88	97	49	68	84
Evidence of psychiatric morbidity (GHQ caseness)	70	70	49	44	53
Any physical complaint (excluding pregnancy)	52	48	35	45*	56

*figures are for women only

Overall, homeless Irish women are notable in having higher levels of opiate addiction and mental health problems than other Irish or UK comparison homeless groups.



Chapter 5

RESULTS III: Health status and health service use

General health

Participants provided information regarding physical health, including disability, perceptions of health status, what symptoms they experienced or chronic conditions for which they been diagnosed, and information regarding gynaecological and obstetric health.

Disability

Eleven women were recognised as disabled by State health and welfare agencies and were supported by the Disabled Persons Maintenance Allowance (DPMA). These included two women who were partially sighted, one women who had childhood polio whose mobility was greatly restricted, two women with mild learning disability / mental handicap and one with muscular dystrophy. The remaining five were registered disabled on the basis of mental health problems. Although not officially registered as disabled, one woman reported caring for herself despite the considerable difficulty of wearing an extensive and particularly awkward caste of plaster-of-Paris for fractures sustained while being restrained by the police.

Perceived health status

Twenty-two percent of the women perceived their health as excellent or very good, compared with 48% of SLÁN[101] survey respondents, while the remainder perceived their health as good, fair or poor. Figure 5.1 provides a view of view of perceived health status by age groups.

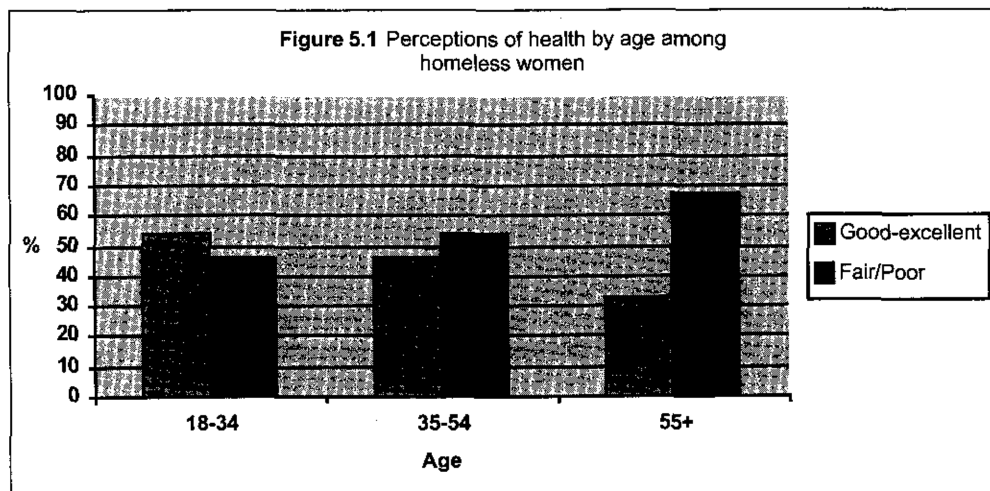


Figure 5.1 Perceptions of health by age among homeless women

Health conditions

Respondents reported experiencing a number of problems. These are listed in Table 5.1 in order of decreasing frequency and compared with similar information for homeless men based in the Feeney et al study. Conditions were grouped together into 4 main categories: mental health problems, chronic physical health problems, physical symptoms and dental health problems. The rates of those experiencing theses problems were compared using a

Fishers exact test. Significant differences were discovered in rates for physical symptoms and chronic physical problems. Differences in overall mental health problems did not reach statistical significance, but when reported depression is isolated and compared between the two groups, the difference is significant. Levels of dental health problems were similarly high for both groups.

Table 5.1 Frequency & gender based comparisons of health complaints among homeless persons

Category of illness	Condition	Homeless women %	Homeless men %
Mental health problem	**All**	**73**	**64**
	Mild mental handicap	2	
	Other psychiatric problems	7	4
	Anxiety	33	50
	Depression	70	52*
Physical symptom	**All**	**72**	**54***
	Foot problems	3	15
	Skin complaints	8	18
	Eye and ear complaints	13	24
	Problems with bones and joints	13	19
	Headache	37	22
Dental health problem	**All**	**51**	**50**
Chronic physical health problem	**All**	**82**	**56***
	Tuberculosis	0	2
	High blood pressure	1	10
	Heart disease	1	7
	Epilepsy	1	4
	HIV+	2	1
	Hepatitis B	3	-
	Peptic ulcer disease	3	10
	Urinary tract problems	4	4
	Bronchitis/emphysema	5	13
	Gastro-intestinal problems	5	4
	Asthma	20	13
	Hepatitis C	25	5*
	Other	7	9

* $p < 0.005$

Mothers with children currently in their care were compared with all other women in the sample across a range of variables related to their health and psychological well-being (Table 5.2). Differences emerged, as outlined, but

only reached statistical significance in terms of physical health and alcohol problems, with the carers of children more likely to have a physical health problem and less likely to have a drug abuse / drinking problem.

Table 5.2. Mothers with children compared to other women in sample on health factors

Health factor	Mothers with children (N=55) %	Other women (N=45) %
Physical health problems	47	80***
Chronic illness	78	87
Opioid addicted	36	60*
Problem drinkers	4	22**
Pregnant	16	4
GHQ casesness	76	62
Quality of life: SEIQoL-DW average (SD)	38.4 (14.7)	38.8 (13.9)

* = p<0.05 ** = p<0.01 *** = p<0.005

Treatment

Although some of the health conditions were reported by a substantial proportion of respondents, many women also reported that they were not receiving treatment for these conditions. For instance, while more than two thirds of the women reported experiencing depression, only half of these reported that they were receiving treatment for their condition (Figure 5.2). Figure 5.2 also demonstrates levels of common conditions and treatment received among the respondents and homeless men in the Feeney et al study (the absence of data for treatment for some conditions for men in Figure 5.2 indicates treatment levels are unknown, rather then absence of treatment). The issue of depression, treatment for depression, and psychological distress is somewhat confused. Psychological distress was measured by the General Health Questionnaire, 70% of women scored above the threshold of 3 indicating caseness. Women who reported depression did so in the context being asked if they suffered from a chronic symptom or complaint, and if they were receiving treatment for the symptom or complaint. Exactly what 'treatment' consisted of was not defined; some women may have taken 'treatment' to mean psychiatric care or consultation, others may have assumed their being prescribed anti-depressants was, or was not, 'treatment'. Some women reporting being prescribed anti-depressants do not report depression as a symptom or complaint. This may be an oversight on their part or confusion may exist regarding what is meant by the terms 'symptom' or 'complaint' Figure 5.3 outlines issues of problem and treatment. One third of the women reported experiencing anxiety. Less than half (45%) of these women were in receipt of treatment for this complaint at this time. Those affected by hepatitis C were among the least likely to be in receipt of treatment (80% reported not receiving treatment). A study among active or former heroin users was conducted in the setting of general practice in the EHRA[150]. Similar to this sample of homeless women, around half of the population of drug users were HCV positive, more than a third of whom had been referred to a specialist hepatology unit.

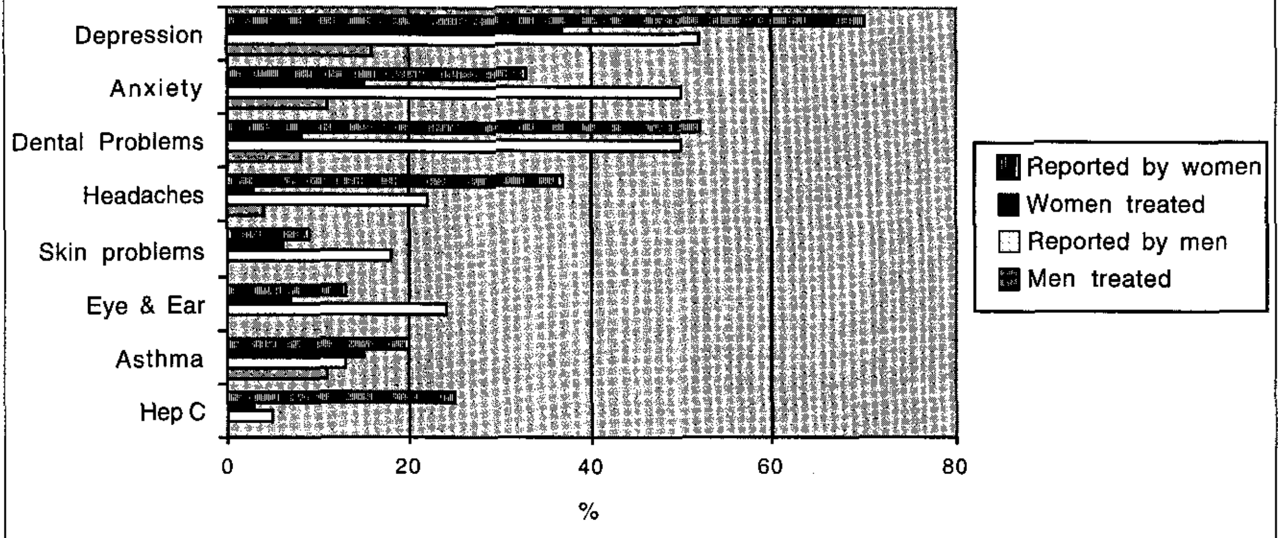
Table 5.3 Treatment for depression by GHQ caseness and reported prescription for anti-depressant medication among homeless women.

Reporting depression as symptom or complaint N=70 (%)		Having GHQ casesness N=70 (%)	Currentry prescribed anti-depressants N=44 (%)
Receiving treatment	37 (52%)	27 (38%)	30 (68%)
Never received treatment	18 (26%)	16 (22%)	4 (9%)
Stopped treatment by own volition	9 (13%)	8 (11%)	4 (9%)
Treatment was discontinued by provider	6 (9%)	5 (7%)	2 (5%)
Not reporting depression	30	14 (20%)	4 (9%)

Obstetric and gynaecological health

Eleven women were pregnant; two at 20 weeks gestation; two at 32 weeks gestation, five at 36 weeks gestation and two at 38 weeks gestation. All were receiving ante-natal care. All women were asked to provide information related to gynaecological health screening. Although 82 of the women were mothers, 32 (39%) had never had a post-natal check-up and a further 3% could not remember whether or not they had done so. Forty-three percent of the women had never had a smear; one women did not know what a smear test was, and one other women had had an amputation of cervix for cervical cancer. Thirty-six percent of women indicated they had never had any form of gynaecological examination (outside of an obstetric setting) and 21% had never had any form of contraceptive consultation.

Figure 5.2 Health problems of homeless persons & treatment received by homeless women compared with homeless men



Counselling

Twenty-eight women were availing of counselling the majority (61%) through the drugs treatment services. A further 3 women were awaiting access to counselling.

PSYCHOLOGICAL WELL-BEING

Social support

Thirty-seven women reported having no close friends and 53 women reported having no close relatives whom they could approach when they needed support. Nineteen respondents reported having neither a close friend nor close relative for support, twelve of whom were mothers caring for one or more children.

The women were asked three questions representative of, and taken from, the component parts of the MOS Social Support Survey;[109] a validated measure of social support and its effect on psychological well-being, and one related question centred on support as a mother. Their responses are outlined in Table 5.5.

Table 5.5 Responses to Social Support Survey (MOS) component questions by homeless women

All respondents (N=100)	**None of the time** %	**A little of the time** %	**Some of the time** %	**Most of the time** %	**All of the time** %
How often would you have someone to show you love & affection?	17	7	24	8	44
How often would you have someone to confide in or talk to about your problems?	15	6	24	12	43
How often would you have someone to help you with your daily chores if you were sick?	33	2	19	3	43
Mothers caring for children (N=55)					
How often would you have someone to help you rear your children?	29	1	15	4	51

Subjective health status

The subjective health status of the sample was measured by the SF-12.[105] The average scores on both components of this measure – the physical (PCS) and mental (MCS) components – are of interest when compared with Irish population norms (Table 5.6).[107] These show similar ratings for self reported physical health functioning between housed and homeless women, but levels of morbidity of self-reported mental health function for homeless women are five times that of housed women.

Table 5.6 Summary statistics for PCS & MCS of SF-12 for Irish population norms and homeless women

Component & Group	**Mean Scores**	**Std. Deviation**
PCS Irish population norms (N=2119)	-5.69	9.33
PCS homeless women (N=100)	-5.55	11.92
MCS Irish population norms (N=2119)	-6.44	7.21
MCS homeless women (N=100)	-30.34	10.53

PCS: Physical Component Scale - a six part measure, within SF-12, of self reported physical health functioning
MCS: Mental Component Scale - a six part measure, within SF-12, of self reported mental health functioning

Psychological distress

Almost three quarters of the sample (70%) scored on or above the threshold score of 3 on the GHQ-12[104], a measure used to detect non-psychotic psychiatric disorder. This compares with 53% of homeless men (Feeney, et al 2000)[98], 21% of Irish women in the Living in Ireland Survey,[101] and 50% of the most comparable group in the

British OPCS[102] survey - the PSLA residents. The group nearest this sample using the GHQ instrument were females incarcerated in Irish prisons; 75% of whom had scores indicating caseness.[113]

Quality of life

A large number of domains of life were identified as being important to the overall quality of life for the respondents. Many of the domains were similar to those identified by homeless men and other groups, including healthy and chronically ill adult groups. The domains identified by the women are presented in Table 5.7 along with those nominated by homeless men and by a group of healthy attenders at an immunisation clinic[114].

Table 5.7 Areas of life nominated as most important to quality of life by homeless women compared with homeless men and with healthy attenders at an immunisation clinic

Areas of importance	Homeless women (N100) %	Homeless men (N = 119) %	Attenders at clinic (N = 42) %
Domains nominated by all groups			
Living conditions (home)	95	63	21
Family	73	63	62
Health	38	57	83
Non-platonic relationships	36	49	86
Finances	35	27	60
Work	27	61	38
Social life	18	36	38
Religion	1	8	7
Domains nominated by homeless people only			
Addiction issues	27	21	-
Friends	20	-	-
Education	9	-	-
Counselling	6	-	-
A 'break' (from childcare)	5	-	-
Security	4	2	-
Personal appearance	3	-	-
Other	2	33	-

The domain of 'living conditions' incorporates the term 'a home' or 'my own place' and was the single most nominated domain among the respondents. While there was considerable consensus as to the most important domains, there was variability in the relative importance attached to each category. For example, of the 95 women who rated living conditions (or home) as one of the five most important areas in their lives, importance ranged from 10 to 90. Similar ranges were found for the other categories. Scores on the SEIQoL-DW ranged from 10.0 to 80.7. The mean score was 38.6, which represents the lowest mean score of any other population for which comparisons are available, including those with motor neurone disease or in palliative care settings. (Table 5.8). The differences between the overall SEIQoL-DW scores of the homeless women and all other groups in the table are highly significant (p is < 0.0005).

Table 5.8 Mean scores on SEIQoL-DW for homeless women and comparison groups

Sample	n	Mean	SD	Range
Homeless women	100	38.6	14.3	10 - 80.7
Homeless men	119	52.3	24.07	2.2 - 100
Healthy samples				
Healthy elderly	56	82.1	12.2	47.3 - 100
Young healthy adults	42	77.4	9.5	52.0 - 95.3
Healthy women eligible for HRT	64	76.5	12.4	7.0 - 96.0
Patient samples				
Peptic ulcer disease	28	72.6	10.7	25.8 - 95.4
Irritable bowel syndrome	28	62.8	10.9	50.9 - 93.6
Osteoarthritis	20	61.6	18.8	27.4 - 96.0
Palliative care	62	60.4	17.50	30.8 - 87.8
Motor neurone disease	28	42.9	27.4	2.0 - 78.1

To illustrate the variety of concerns and levels of quality of life of these women, profiles for three respondents are shown in figures 5.5 to 5.7. Although there was some overlap in the life domains nominated by all three as important to quality of life, there was considerable difference in overall quality of life scores. Three cases, representing the lowest, highest and mid-point on the SEIQol-DW scores, illustrate the point. Figures show the 'level' or current status of function for life domain; scores of zero mean 'worst possible' with 100 meaning 'best

possible'. The second set of bar-charts (weights) refer to the relative value assigned to each of the five life domains nominated – higher weightings illustrating relatively more important domains.

Figure 5.5 represents the quality of life of Case A, a married woman, homeless for three months, currently in private hostel accommodation. This women had a long history of serious physical violence in her home. When her violent husband was eventually jailed, she found that her home and family, in a flats complex, became the focus for harassment by neighbourhood bullies. Denied the 'protection' of her violent partner, the problems escalated to the point of gang rape of her fourteen year old daughter by the bullies. In attempting to accompany her daughter in an ambulance following the rape, she was restrained by police officers and suffered a broken arm in the process. At the time of interview this woman she was temporarily disabled by the plaster-of-Paris caste she was wearing, had put her children into care for their own protection and had left her home to escape her tormentors, thereby becoming homeless. Her quality of life score extremely low at was 10.0.

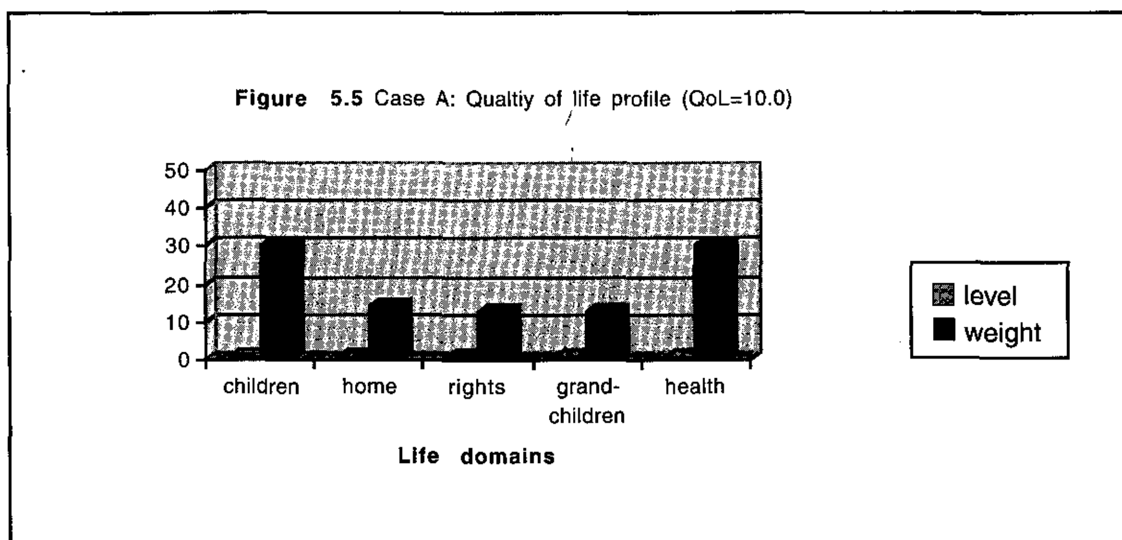


Figure 5.5 Case A: Qualtiy of life profile (QoL=10.0)

The highest scoring respondent on the SEIQol DW was a young unmarried woman - Case B (Figure 5.6), in hostel accommodation who suffered from bi-polar manic depression, and had first become homeless three years prior to interview, on the death of her mother. She had a problem with alcohol dependency, exacerbated by a mental problem which was currently under control. She had two children who had been reared since infancy by their father – an arrangement which suited all concerned. The support she received from the ERHA hostel staff in which she was being accommodated was highly valued by this women, and she attributed much of her current stability to their help. Her quality of life score was 80.7.

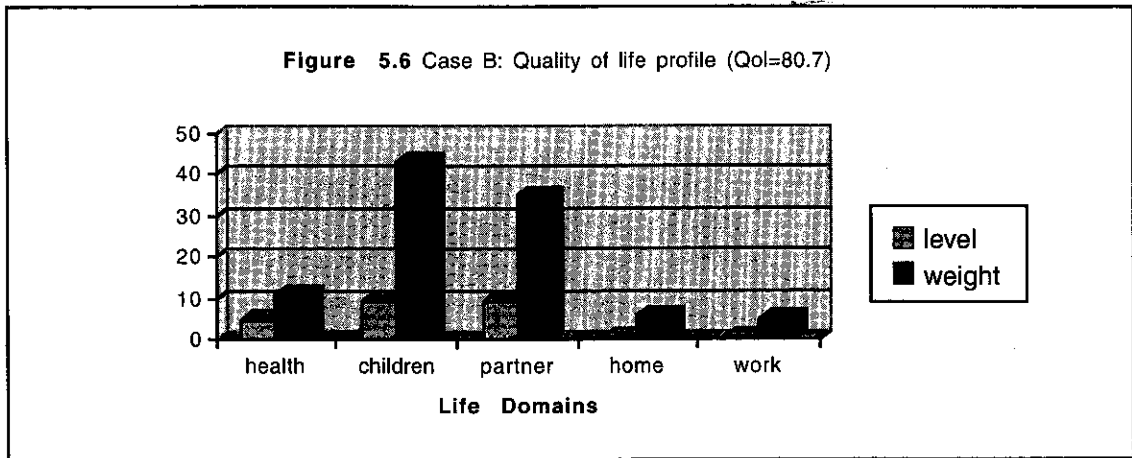


Figure 5.6 Case B: Quality of life profile (Qol=80.7)

A woman scoring nearest the mid-point on the range for SEIQoL - Case C (Figure 5.7) was a young single mother, homeless on and off for about 10 years, and for about 12 months at the time of interview. She was accommodated in a private hostel. Her three year old daughter was currently living with her family. She was alcohol and opiate dependant and on a methadone maintenance programme. She had made repeated attempts over the previous 10 years to maintain an opiate and alcohol-free lifestyle, but had relapsed numerous times. She supported herself through prostitution and had experienced multiple incidents of rape and violence as a result. Her quality of life score was 38.5.

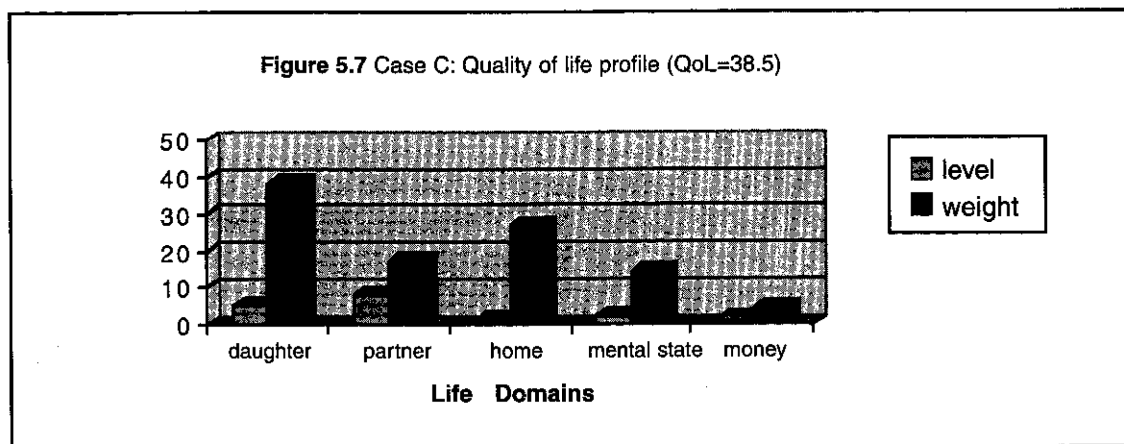


Figure 5.7 Case C: Quality of life profile (QoL=38.5)

These case profiles illustrate the wide range of dimensions important to quality of life and the differing quality of life levels experienced by women in the study.

USE OF HEALTH SERVICES

Medical card ownership

A significant minority of women (41%) did not hold an up-to-date GMS medical card (Table 5.9). A number of reasons were given in explanation. Some women had cards which were out of date, or they were in the process of applying for a card or were about to apply for a card. Some women felt their GP service needs were met by 'their doctor' in the drug treatment services, or by a general GP service provided by the ERHA hostel in which they were staying. However 10 women who did not have cards failed to apply because they understood they needed a permanent address to do so. When asked about any difficulties encountered when applying for a medical card five women reported problems with having GPs accept them onto their practice registers. One woman wanted access to a female GP but could not be facilitated within the catchment area of her accommodation. Of the 57 women with medical cards 37 (65%) were mothers whose children live with them; 18 mothers whose children live with them (33%) do not have their own medical card.

Table 5.9 Medical card ownership & related issues among homeless women and homeless men

		Women (N=100) %	**Men (N=171) %**
Medical card ownership	Currently has card	59	61
	In process of applying	13	12
	"Don't need a card"	12	17
	"Can't get a card"	10	4
	Other	5	2
	Card out of date	1	4
For those without medical cards:			
Are you eligible for a medical card?	Yes	69	71
	No	24	21
	Don't know	7	8
Know where to go for a medical card?	Yes	92	80
	No	8	20
All respondents:			
Difficulty getting your medical card?	No trouble	58	63
	Haven't tried for one	17	24
	Difficulty in completing forms	-	1
	Difficulties re acceptance by GP	5	0
	Other	30	12

Access to health services

In the six months prior to taking part in this study, more than three-quarters (83%) of the respondents had accessed the health services via GP, A&E services or outpatient services. This compares with 73% for homeless men in the Feeney et al study.

GP services were the most frequently used, with 67 women reporting at least one visit solely for themselves (N=35), solely for their child(ren) (N=5), or a visit for both mother and child(ren) (N=27). Table 5.10 outlines the percentages of respondents utilising services.

Table 5.10 Service used by homeless service users in 6 month period

Service	Visits for homeless women %	Visit for child(ren) by homeless mothers %	Visit for mothers and child(ren) as family unit %	Visits for homeless men %
GP	35	32	27	61
A & E	25	16	5	30
Outpatient department*	42*	11	6	28

*Inclusive of visits to ante natal-clinics

Access to general practitioners

Of the 67 women who had visited a GP in the previous six months, 40 reported more than one visit. There was an average number of 5.6 visits for adult females and an average of 3.6 visits for their child(ren). The majority (71%) returned to the same GP for each visit, while five women (7%) visited two, and one woman visited four different doctors. Respondents were asked about their most recent visit to the GP. The most common single reason for an adult visiting a GP was because of a general physical illness (42%), pregnancy alone was the reason for visiting a GP in 15% of cases with a combination of general physical illness and pregnancy related reasons accounting for 3% of GP visits. Repeat prescriptions for psychotropic drugs was the reason for visits in 35% of cases ; 10% visited for repeat prescription for psychotropic drugs and general physical illness combined. Reasons for children's visits to services are reported in Chapter 7.

In general, women reported being satisfied with their most recent GP visits; 71% were satisfied, 16% dissatisfied, the remainder were neutral. Complaints regarding GP services include one young mother who was refused emergency post-coital contraception by her GP and had to go to A&E for this service; the evidence for GP refusal of contraception is evidenced in other Irish studies.[116-118] Two women felt stigmatised in general practice surgeries because of their status as homeless women. The majority of complaints related to poor communication skills and attitude of the GP.

Access to Accident and Emergency services

Forty-one women reported having attended A&E services in the previous six months on at least one occasion; 63% of whom (N=25) visited as adults for their own problem solely; 24% (N=11) took their child(ren) to A&E; 13% (N=5) attended for both their own health reason and for problems related to their child(ren).

Those women visiting for personal health reasons (N=30) had between 1 and 4 visits each (with a median figure of one visit). Their reasons for attending were related to mental health in four cases, general physical health problems in 19 cases and in seven cases the women had been admitted for drug overdose (whether accidental or otherwise was not addressed). Twenty of the adult attenders at A&E (66%) had also been to the GP in the same period, five of whom had been directed to A&E by the GP. This compares with 69% percent of the male A&E attenders who had also visited a GP in the same time period in the Feeney et al study.

Just over half of the women (51%) reported being satisfied with A&E services, whether for themselves or their child(ren). Eleven women were dissatisfied – mostly because of the delay in waiting to be seen. One woman lost her booking for hostel accommodation for the night, because she could not been seen by medical staff in time for admission to the hostel. (Most hostels have a policy whereby persons booked for admission must present themselves for admission by a pre-set deadline.) Two women complained of negative staff attitudes which they felt were related to their drug problem.

Access to hospital out-patient department (OPD) services

Thirty six women had visited OPD for their own health reasons, eleven for their child(ren) and six for both. Of the 42 women who had visited for their own health problem, the median number of visits was 4.5, with 62% visiting more than once. Fifteen women (36%) were regular attenders at psychiatric outpatient services, eleven (26%) attended for ante natal services, and the remainder attended for various physical health problems, including one women with ovarian cancer attending for chemo-therapy. Twenty-six of all the women attending OPD (55%), whether for themselves or their children, were satisfied with services, 13% were not; the remainder were neutral. Dissatisfaction related mostly to waiting time in the children's OPD.

In-patient hospital services

Forty-one women had been in-patients in the previous twelve months, 15 of them on more than one occasion. The median stay was seven nights in hospital. In 19 instances the admissions were for psychiatric illness, eleven were for pregnancy-related reasons and three in patient stays were for pre-arranged opiate detoxification. The remainder were for general health reasons ranging from trauma to asthma attacks. One women had discharged herself from hospital against medical advice because she was concerned about her children's wellfare; for another her complaint requires re-admission but she refuses because she cannot access childcare. One of the women who gave birth recently continues to breastfeed her child successfully, but another complained of lack of support for her wishes to breastfeed while an in-patient, which led to her abandoning the effort.

GMS status and general health

Medical card holders (persons registered with GMS) were compared with non-card holders in terms of health problems and access to services (Figures 5.3 & 5.4). Data for homeless men represented in the Feeney et al study were included in the comparisons, to illustrate the manner in which health problems and service access are distributed across the groups.

Figure 5.3 Health problems experienced by GMS status & gender of homeless persons

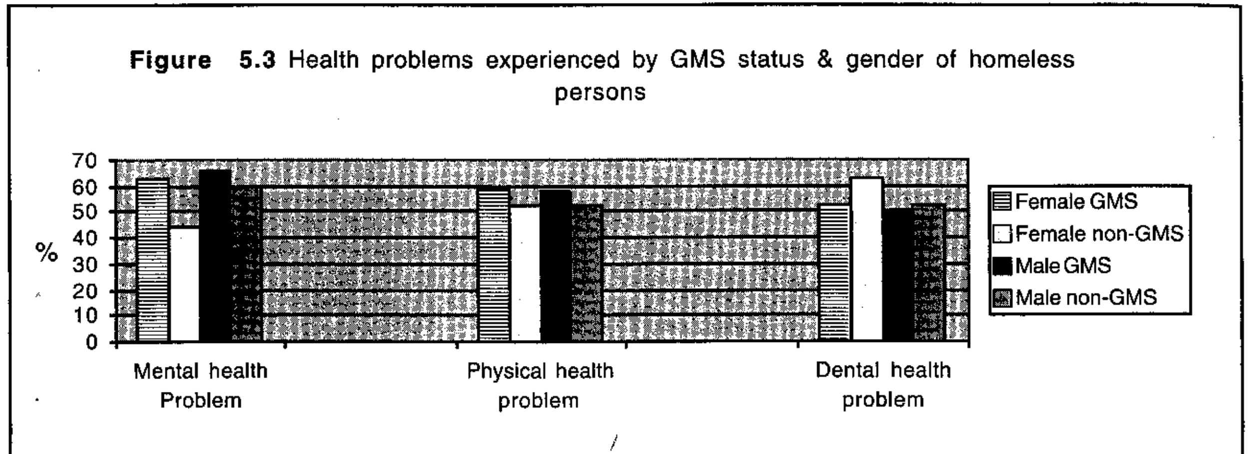
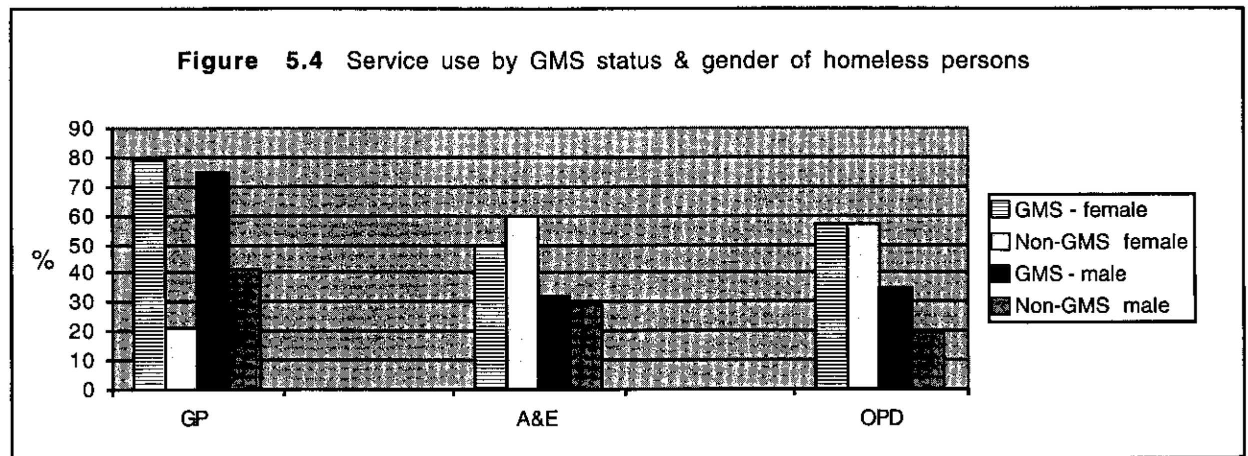


Figure 5.4 Service use by GMS status & gender of homeless persons



Those least likely to use GP services were non-GMS women. These were also the group most likely to use A&E services although the excess A&E use was not equivalent to the lower level of GP consultation.

Chapter 6

RESULTS IV: Lifetime experience of physical & sexual violence

Physical and sexual violence will be reported separately for the purposes of this study, while acknowledging that both forms of violence often occur together. Lifetime experience of abuse for women and children was queried. Comparisons with other studies are difficult. National data on physical or sexual violence is not available in Ireland. (However a national prevalence study for lifetime sexual abuse is currently underway and results will be available by February 2002)[120] The physical and sexual abuse questions were not asked in Feeney et al's study of homeless men.

Childhood experience of physical violence

Forty women reported having experienced physical violence in childhood, three of whom preferred not to give further details of same. In response to the question "Did you ever experience violence as a child?" eight women reported having witnessed 'domestic' violence – in seven cases their mothers being beaten by their fathers, in one case both parents being violent to each other. None of these women reported violent behaviour toward themselves but all described what they witnessed as being very distressing. The perpetrators of violence against those women who reported childhood experiences of violence are outlined in Table 6.1.

Table 6.1 Perpetrators of physical violence against homeless women in their childhood

Perpetrators	Childhood victims %
Father only	48
Both parents	16
Other relative	16
Mother only	8
Mother's partner	5
Carer / guardian	5
Stranger	5

All thirty-seven women reporting details of physical violence in childhood said it happened in their home, three of whom said besides their own home, they had also experienced violent attacks in other locations – one while in care, one in a relative's home and one on the street, by adult strangers. Three women reported the violence against them began in their teenage years; for the remainder it began in early childhood, occurred regularly, and lasted through-out their childhood years.

For eight women, the violence only ceased when (and because) they left home (in one case to be fostered because of the experience of violence and neglect); for three women the violence persisted into adulthood, for the remainder it ceased late in their teenage years – "when I hit her back" one woman said.

Of those women reporting details of childhood experience of physical violence (N=37), 46% (N=17) said they needed medical attention as a result of the violence they experienced; nine women (24%) reported social worker involvement resulting from childhood violence. Ten women (27%) reported needing, but not seeking, help. Two said they were actively prevented from getting help by the adult involved.

Adult experience of physical violence

Fifty-five women reported the experience of physical violence in adulthood (62 % of whom had also experienced violence in childhood). The majority (80%) reported the violence they experienced was in the context of a single long-term relationship with a husband or partner. Six (11%) women had had violent relationships with more then one long-term partner. One women experienced violent behaviour from her adult son as well as her husband. For one woman the perpetrator was her violent father; another was in a violent lesbian relationship. One woman reported being a perpetrator as well as victim of domestic violence (her partner had taken a barring order against her). Three women reported the violence they experienced as being isolated incidents; two of whom had been badly beaten by customers. These women were sex workers at the time.

Time-scale and location of experiences of physical violence

For 60% of the women, the violence they experienced began before they were 21 years of age. Five (9%) women reported ongoing physical violence from a former partner, when they were unable to avoid him; four perpetrators of violence against the women were now in jail for unrelated convictions. For the remaining women in violent relationships, the violence only ended when the relationship ceased. For 85% of the women, the main location for the violent behaviour was in their own home. Nine percent had experienced violence 'on the street', but in most cases this was the action of the perpetrator 'at home' who also attacked her in the street. For at least 14 women, becoming homeless (by leaving the violent partner) was the only way they could escape the violent behaviour they had experienced.

Action taken in response to physical violence experienced by homeless women

Thirty-four women sought medical attention as a result of the violence they experienced, eight of whom (24%) lied about what had happened (one told the truth on subsequent occasions). The majority of women (70%) told the doctor what had happened voluntarily, but two women said they never told and were never asked what caused their injuries.

Thirty-five women sought help, apart from medical attention, for domestic violence; thirteen sought legal help through the courts and/or police; ten received marriage counselling, seven succeeded in availing of a refuge for battered women. Some women sought and / or accessed more than one type of service or assistance for the problem.

Responses to help or services accessed for women who experienced physical violence

Sixty-two percent of the women who accessed help were satisfied with the services they received, 24% were not; the remainder were neutral. The most commented-upon services were the legal and counselling services – the former generally seen as ineffective, the latter as irrelevant. One woman remarked "The judge won't be around if he (her violent husband) comes looking for me, and the coppers don't want to know". Another said "It's a joke

(referring to counselling services). *He leaves you half dead and they want to talk to you about preserving the marriage*".

Thirty-one women gave reasons for delaying or failing to seek or access help for the problem of physical violence, some gave multiple reasons. Table 6.2 outlines the reasons they gave.

Table 6.2 Reported reasons for failing to seek help for physical violence experienced

Reason	**Number of women for whom it applies N=55 (%)**
Afraid of retaliation	11 (20)
Thought she could handle it herself at first	9 (16)
Too ashamed	3 (6)
Did not know where to look	3 (6)
No services available	3 (6)
Too trivial	2 (4)
Told police – they refused to get involved	2 (4)
Did not want to break up the marriage	1 (2)

Sexual violence - overview

This section of the interview was prefaced with a repeat of the clarification to women that they could participate or not as they felt appropriate. For those with children, they were cautioned in advance that reports of sexual abuse concerning their children would be subject to reporting to the authorities if the cases were not already known to them.

Forty-nine women had experienced some form of serious sexual violence, assault or abuse in their lifetime. The term sexual assault is used here to describe all forms of unwanted / uninvited sexual acts of an aggressive nature that involved contact but not penetration. Contact involving penetration is described as rape. Verbal or emotional abuse, harassment, threats, 'stalking' etc. of a sexual nature were not accounted for in the figures. Seven of the 49 women, while acknowledging they had suffered some form of sexual violence, assault or abuse opted not to provide further details – mostly because they became very upset. Two of theses women acknowledged they had been raped (one of whom indicated she was not homeless at the time); the extent of the abuse experienced by the remaining 5 is not known. Most women for whom details are known, had been victims of rape at least once in their life. Of those who indicated they had been raped, six also indicated separate instances of sexual assault (i.e. separate in that the incident(s) involved a different perpetrator). In table 6.3 each woman is counted only once and is designated into the category of the most serious type of abuse experienced.

Table 6.3 Types of serious sexual abuse experienced by accommodation status of women when abused

Abuse	Not homeless at time of abuse N	Homeless at time of abuse N	Abuse occurred both while homeless & housed N	Unknown accommodation status at time of assault N	Total
Rape	22	6	3		31
Sexual assault	9	3			12
*Assault-details not complete	1			5	6
Total	**32**	**9**	**3**	**5**	**49**

• "prefers not to talk about it"

Sexual violence and the role of homelessness

Table 6.3 describes the profile of sexual violence by accommodation status. Most women (32 of 49; 69%) were abused before they became homeless. This relates partly to age of abuse as seen below. When asked directly, 14 women said the sexual violence they had experienced either directly caused or significantly contributed to, their becoming homeless. Three of these women were the victims of physical as well as sexual violence from partners and had become homeless as a direct result of leaving the violent relationship; the remaining 11 had been abused as children in the family home; 4 by their fathers and the remainder by other relatives, all before the age of 13 years.

Eight women indicated that a period of homelessness, had preceded sexual assault – five were raped (two by strangers, two by a relative and one by an acquaintance) and three were sexually assaulted (one each by a stranger, a partner and a relative). All eight women first experienced abuse in adulthood. Only one woman, raped in adulthood by a stranger while homeless, had not experienced sexual violence before becoming homeless.

Sexual violence: where?

The women were asked to indicate where the abuse took place. There were multiple locations and instances for some, particularly for those women who had been the victims of more than one perpetrator. For some women, particularly those who suffered rape and/or sexual assault as children, the details reported mostly pertain to the more serious crime of rape. Because of the sensitive and distressing nature of the topic, limited probes were used to separate out the details of all instances of abuse where a complex or lengthy history existed. Table 6.4 outlines the information available; discrepancies between the numbers reporting any abuse (N=49) and the totals outlined are because some women reported many events and details and some withheld details.

Table 6.4 Age when abuse began by location of the abuse

	< 8 years	8 – 12 years	13-14 years	15-17 years	18+years
	N	N	N	N	N
Home of the victim	11(6*)	6(*2)	2 (2*)		7(2*)
Home of the perpetrator	2	3	1	1(*1)	3
Neutral place			1	1	1
On the street					8 (7~)

*Indicates victim & perpetrator are known to have shared the same home at the time – e.g. of 11 cases under the age of 8 in the victim's home, the perpetrator also lived there in 6 of these cases.
~ Indicates numbers responsible who were strangers – in 3 instances the perpetrator was the customer soliciting the woman who was engaged in prostitution

Sexual violence: by whom?

The perpetrators of rape and sexual assault against the women are outlined in Table 6.5. Some women were abused by more than one perpetrator; all but one of the perpetrators were male; there was one instance of abuse by a female. This occurred when the woman was a child in care – the perpetrator was resident in the same institution. This person's status there was not clear. In 48% (N=15) of rape cases, the perpetrator was a relative.

Table 6.5 Relationship of perpetrator to victim

Perpetrator	Respondents N
Father	6
Grandfather	4
Step-father	3
Uncle	3
Brother	3
Cousin (male)	1
Other (unspecified) relative (male)	3
Family friend or neighbour (male)	5
Other person known to victim (male)	6
Partner (5 male: 1 female)	6
Stranger (male)	12
Other (male)	3

There was more than one perpetrator or episode in some instances; in total 55 perpetrators were identified by 42 women.

Sexual violence: when?

The age categories of the women when the instances(s) of sexual violence first occurred is outlined in Table 6.6 The specific age at abuse first began is indicated in Table 6.7.

Table 6.6. Age profile of women at onset of abuse and type of abuse experienced

Age (years)	Rape N (%)	Sexual Assault N (%)
<15 only	14 (46)	15 (%)
15-17 only	2 (6)	1
17+ & 18	4 (13)	5
18+	11 (35)	3
Total	**31**	**24**

Only five women said the rape or assault they experienced was a single incident; 20 women endured sexual violence for an average of 5.4 years (SD: 4.5; Range 1-20 years). The remainder who indicated a timeframe estimated the period for which they experienced abuse to have been throughout their complete childhood or adulthood – one women said "all my life".

Table 6.7 Age when the sexual violence first began

Age	Respondents N
Early childhood	1
3	1
4	1
5	2
6	5
7	5
8	3
9	1
10	2
11-14	6
<15	1
16-18	4
19-32	4
Adulthood	7
Total	**43**

**Missing are those women 'who did not want to talk about it' or began to give information and then desisted.*

Sexual violence: disclosure

The women were asked if they had ever disclosed what had happened to them, either directly following an experience of rape / sexual assault or at any time later. Less than a third of the women had disclosed at the time of the abuse.

Table 6.8 Time of sexual abuse by time of disclosure for homeless women

Time of life when abuse occurred	Disclosed at the time abuse occurred N	Did not disclose until a later period (*in life) N	Never disclosed before current study N
Childhood	7	13 (*as child)	1
		7 (*as adult)	1
Adulthood	6	7	1
Total (%)	**13 (31%)**	**27 (64%)**	**2 (5%)**

Sexual violence: responses to seeking help

The following scenarios, not mutually exclusive, were indicated as having occurred as a result of sexual violence. Seeking help and availing of it was not necessarily immediate, and in most cases involved considerable time lapse.

Table 6.9 Professional services needed, sought and received for sexual violence

Service issue	N (%)
Needed and got medical attention	15 (31)
Needed but did not look for professional help*	18 (37)
Looked for and got professional help*	10 (20)
Looked for, but did not get help	4 (8)

* *'help' referred to includes medical help*

For those who did not seek help, reasons are presented in Table 6.10. Some women indicated a variety of reasons.

Table 6.10 Reasons for not seeking help for sexual abuse

Reason	N (%)
Did not know where to look	9 (20)
Fear of retaliation	8 (16)
Did not understand what was happening at the time	4 (8)
Was afraid to cause trouble in the family	4 (8)
Did not understand what was happening	4 (8)
Too ashamed	2 (4)
Would not have been believed	2 (4)
Was too involved in drug abuse to do so	1 (2)

Women who accessed help were asked the about type and effectiveness of the help received in a series of open questions. Counselling was the most common and the most valued form of help available to the women. Methods of referral and access varied widely; a total of 23 women accessed counselling through the following agencies: Rape Crisis Centre (6 cases), psychiatric services (3 cases), social worker referral, drugs treatment centres and legal/justice systems (2 cases each). Eight others identified different / diverse options.

Of those who expressed an opinion (N=12), the majority of nine women (75%) were satisfied or warmly appreciative of the counselling they had received, while three women were not pleased. The remaining 13 women were non-committal when asked. One women, in a particularly distressed state following the abuse, had been refused counselling because she was on a methadone maintenance programme.

Sexual violence: getting justice and protection

Recourse through the legal system caused more problems than it solved for the three women who pursued that option. One woman reported the perpetrator to the police. He was taken in for questioning and then released – she was subsequently beaten severely as a result of "grassing him up". Another woman now in her thirties, reported her abuse to the police as a fifteen year old girl and was turned away. A third case was of a woman who avoided her violent and sexually abusive partner. She eventually secured a barring order against him. This legal process allowed her abuser to find out her new address and she subsequently was raped and beaten by him, with great violence.

Open questions addressed the issue of how the abusive behaviours experienced by the women were brought to an end. Table 6.11 categorises and outlines the responses.

Table 6.11 How/when sexual abuse was ended or avoided

Event	N (%)
Victim left the environment where abuse occurred	12 (24)
Disclosure lead to cessation	8 (16)
Learned to avoid perpetrator	5 (10)
The perpetrator was removed (barring order N=1; imprisoned N=2)	3 (6)
Death of perpetrator	2 (4)

Sexual violence: case histories

The quantitative information presented can be more thoroughly appreciated when details of the lives of some of the individuals are considered.

<u>Example 1.</u>

This woman, now in her thirties,
has had multiple episodes of hospitalisation
for self harm and suicide attempts.
She described how from early childhood she
was raped repeatedly by her father who also made
her available to a paedophile ring.

> *"..I don't remember any of their faces, just the pain and feeling like I couldn't breathe and the flash of the camera when one of them would be on top of me.."*

Example 2.

This women, in her late twenties and with 3 children, was regularly raped by her alcoholic father in childhood, and impregnated by her first "boyfriend" who beat her severely and mutilated her genitalia with a Stanley knife. One of her own children was also abused by the child's grandfather (i.e. the same abusive relative). The woman also suspected sexual abuse of another child who spent some time in care while her mother was in prison for stealing to feed her drug habit. This woman has been awaiting access to a counsellor for the past 3 months, with increasing desperation.

Example 3.

As a child, this woman was reared by her grandparents when abandoned by her own mother. She was sexually abused by her grandmother's partner from the age of three years – the grandmother was complicit in the abuse.

Example 4.

This women, when she complained as a child to her mother of her grandfather's assault and rape of both herself and her younger sister, was told by her mother to

"..shut up about it ... you must have deserved it anyway..".

Abuse of the children of homeless women

Of the 100 women in the study, 82 were mothers 80 of whom have a total of 173 children under age 18 years. Eight of the 100 women knew and/or strongly suspected that their child(ren) had been sexually abused. Seven of these women had themselves experienced sexual violence. Six of these women (86%) had become homeless as a consequence of removing their child(ren) from the abusive situation. One woman put her child into care because she felt the environment in the B&B was unsuitable for her child. Now she strongly suspects that her child was sexually and physically abused while in care. Thus homelessness may be a consequence of mothers trying to find a safer place for children than their own homes.

Sexual violence and homelessness

The profile of the women who had been abused before becoming homeless was contrasted with those not reporting abuse in order to consider whether such experiences were associated with homelessness. There were no differences of statistical significance in terms of current age, age at first homelessness or in number of children between abused and groups in Table 6.12.

Table 6.12. Demographic profile of women not reporting sexual abuse compared with women reporting sexual abuse before becoming homeless

	No abuse reported* **N=51**	**Abuse before becoming homeless** **N=34**
	Mean (SD); Median ;Range.	Mean (SD); Median; Range.
Current age (years)	28(10.7); 25; 17-65 .	23(7.0); 25; 18-44.
Age at first homelessness (years)	25(10.9): 21: 12-64	23(7.9); 21; 10-40
Number of children	2.5(1.9); 2; 1-7	2.4(1.5); 2; 1-6

*Women abused since becoming homeless (N=8) or women reporting abuse but unwilling to give further details (N=7) were excluded from these analyses

Another important comparison is between women grouped on the basis of reporting ever or never having experienced sexual violence (Table 6.13). Some differences did emerge; for women who had experienced abuse, this was less likely to be their first episode of homelessness; they were less likely to have social support in terms of supportive relatives; they were more likely to have experienced physical as well as sexual violence in their childhood and adulthood and more likely to have used anti-depressant medication.

There were few statistically significant differences across a wide range of variables. Differences between the groups in terms of alcohol and heroin use, reporting of chronic illness and gynaecological health and practices were not significant. Measures for psychological well-being (GHQ scores) and quality of life indices (SEIQol-DW scores), while indicating both groups fare poorly compared with the general population, are not significantly different.

Table 6.13. Experience of sexual abuse by social, lifestyle and health factors, and parenting

Factors	Ever reporting sexual abuse % (N=49)	Not reporting sexual abuse % (N=51)
First time homeless	47	75**
Childhood exp. of physical violence	67	31***
Adult experience of physical violence	88	41**
No supportive relatives	67	33***
Ever taken anti-depressant medication	61	36***
Ever used heroin	49	43
Problem alcohol use	16	8
Reported chronic illness	90	75*
Ever had a smear test	59	50
Ever had any gynae. exam	61	62
Ever had contraceptive consultation	80	75
Currently pregnant	8	14
GHQ 'cases' i.e. score ≥ 3 (%)	69	71
% of group having children	82	82
% having none of their children in their care	47	19*
Quality of life: SEIQol scores Mean (SD); Range	36.1(14.4); 8-55	40.4 (14.7); 11-70

* = p<0.05 ** = p<0.01 *** = p<0.005

Location of childcare for sexually abused mothers

Of the 49 abused women, 40 had 86 children in total, under the age of 18 years. Sixteen of these women (40%) had all of their children with them; 5 (13%) had some of their children with them. Table 6.13 compares abused and non-abused mothers in the study in terms of the location of the care of their children.

Lastly, although the study did not formally enquire into the matter, anecdotal evidence emerged of sexual harassment of some women by owners/caretakers of emergency accommodation.

Chapter 7

RESULTS V : Children of homeless women

Eighty-two of 100 women in the sample were mothers; 80 of whom have a total of 173 children under the age of 18 (94 females, 79 males). These children have a median age of 6 years (average age of 6.8; SD 4.6. Range: 2 months to 17 years). Individual family size is a median of 2 children (mean: 2.2; SD: 1.3; range: 1-7).

Childcare arrangements

The women were asked if their children were currently living with them (this provided a working definition of the mother as 'primary carer'). Just over half of the group (52%) had all of their children (under 18s) living with them; 13 women (16%) had some of their children living with them while the remainder (32%) had none of their children in their day-to-day care. They were also asked to indicate the proportion of the previous 12 months that each child had lived with them (Table 7.1). For 55 children, the location of their care had been shared during the previous 12 months; an outline is provided (Table 7.2) of these locations alongside the location of current care arrangements.

Table 7.1 Proportion of previous 12 months child lived with his / her mother

Living arrangement	Children N (%)
all the time living with mother	86 (50)
> than 50% of the time living with mother	10 (6)
< 50% of the time living with mother	9 (5)
none of the time living with mother	68 (39)

Table 7.2 Living arrangements for children of homeless women in previous 12 months

Adult(s) caring for child	Currently N (%)	*Within past 12 months. N (%)
Their (lone) mother (i.e. homeless woman)	64 (36)	17 (10)
Their father	27 (16)	11 (6)
In family unit – with mother, surrogate/father & (some cases) siblings	24 (14)	10 (6)
In care / fostered	22 (13)	4 (2)
With other members of mother's family	17 (10)	10 (6)
With other members of father's family	15 (13)	2 (1)
Adopted	2 (1)	
In sheltered accommodation	1 (0.5)	
Long stay hospital care	1 (0.5)	
Total	**173**	**55**

*These figures indicate others, besides the current carer, that a child lived with in the past 12 months.

Homeless children

Ninety children were currently living with 55 homeless mothers in emergency accommodation. Their average age was 5.6 years (range 2 months to 17 years). Table 7.3 lists the ages of these children.

Table 7.3 Ages of children living with their mothers in emergency accommodation

Age	N	(%)
< 12 months old	10	(11)
12 - 23 months	11	(12)
24 - 35 months	10	(11)
3 - 4.9 years	14	(16)
5 - 9.9 years	29	(32)
10 – 14.9 years	10	(11)
15 – 17 years	6	(7)
Total	**90**	**(100)**

Qualitative information: suitability of emergency accommodation in caring for children

Most of the interviews with homeless mothers accommodated in B&Bs were conducted in their living area, which in most instances was a single room. The circumstances in which these mothers were caring for their children were very obviously unsatisfactory. Aspects of the nature of the accommodation provided are outlined below; comments made by the women are quoted or synopsised and outlined in point form together with researcher observations considered relevant to child health in this setting.

- One woman reported how one of her small children sustained a fractured arm when he fell down a steep flight of stairs in the B&B

  "..the sort of stairs you'd have put a barrier on if you had your own place.." she explained.

- *"The water from the tap in the room doesn't taste right, I always boil it before making the baby's bottles, but you wouldn't know how long them pipes have been there or what's in them.."*

  A mother of a young infant complained about the quality of water available in her room in the B&B. She explained that in the daytime she had permission to fill a kettle in a kitchen not usually accessed by the residents but in the evening and night-time, this access was denied.

- Many women complained about the cost of eating out. Some had minimal cooking facilities in their rooms, a kettle and a small fridge; most had no facilities for food preparation or storage. Providing hot meals for their children was possible only by using restaurants, which the women considered not only very expensive, but of poor quality.

> *"Burgers and chips is what they get mostly. I don't know how long it is since they had a decent meal with red meat and vegetables"*

- Laundry was another very expensive project for most women who lacked any facilities other than a hand basin and radiator, for either washing or drying clothes for a young family. One women said her laundry bill at the local launderette was more than a quarter of her income that week – her children had had gastro-enteritis for a number of days.

- Almost half of the owners of B&B accommodation providing places for the women in the sample required that their residents vacate the premises for a given period of time during the day – usually from around midday to between 5 and 7pm in the evening. Walking the streets or finding an available place to sit and rest during these times, especially with young children, was one of the most difficult aspects of their lives. Concerns about cold or inclement weather, nowhere for toddlers to nap or play, the dangers of traffic and the stress and exhaustion of having to be constantly on the move were expressed by the women. It was not only the younger families who were affected in this way – one woman complained of how, for her 15 year old son, life was becoming impossible.

> *"He* (15 year-old-boy) *doesn't want his pals to see him always hanging around with his ma - and what am I supposed to tell him – go and hang around the streets by yourself? That's exactly what the guards will tell him not to be doing".*

- Two women in their sixties who were rearing children also complained of the toll that being outdoors in all weathers took on their own energy levels, and how in turn this affected their relationship with the children in their care.

> *"I just don't be able for them"* is how one grandmother put it.

- For women who were allowed to remain in their room throughout the day, the burden of "finding somewhere to go" was replaced by the stress of a cramped, confined environment - the children in most instances had no play area outside of their room. Their sense of isolation the lack of a supportive environment and respite from the demands of young children, were reported as a source of grave distress to most of the women. Many were being treated for depression, few had access to getting what most said they wanted which was

  ".. a break from the kids even for an hour.."

  as one woman put it.

  Their lack of ability to access help with child care and to be able to have

  "..some life for myself.."

  was a complaint common to many of these women who acknowledged that this impacted on the way they related to their children.

  "Kids shouldn't have to say 'Mammy what are you crying for?'.. or get shouted at for doing nothing except being kids".

- In B&B accommodation most families were not allowed visitors to their room (in some instances this included the researcher). Some women remarked on the way this stigmatised not just them, but their children also. One women complained of how although she was delighted to have recently been accommodated in an 'apartment' instead of a single room, her nine year old son complained about not being able to bring his school friend to his home. The child was embarrassed by this, his mother explained, as she recounted a recent complaint made by her son:

  "..we're always going to his house and he never comes to mine - his mother wants to know why'... That's what he said to me the other day ... It's as if we're being punished for being homeless"

Contact with other family members

The issue of contact with family members for children of homeless women was explored. Eighty-three children of homeless women did not live with their mother; 43 of these have had contact with her in the past 12 months; 40 children (almost half; 48%) did not. Of the total of 173 children under 18 years, 51 lived with their father (24 within the family unit that includes both parents); a further 45 have had contact with him in the past 12 months. Contact with any or all grandparents was common, as was contact between siblings with mothers reporting contact between grandparents and grandchildren in 103 cases; 101 children had contact with one or more of their sibling(s) in the past 12 months.

School

Of those women caring for their children in emergency accommodation (N=55), more than half (58%) of the women had 52 children of school-going age in their care; 7 children were in secondary school; 22 in primary; 13 in 'infant' school. Seven children had left school before the age of 15 (one of whom was in contact with outreach services), 2 at the age of 16 years (one because she was pregnant); one 5 year old had been regularly attending infant school but the mother had been asked by the education authorities to keep him home because he was unruly and had been diagnosed as suffering from Attention Deficit Disorder (ADD). No alternative arrangements were offered.

The women were asked about their children's school attendance record and the numbers of different schools their children may have attended during the past school year. Eight mothers (15%) indicated their children attended school for less than half of the school year; 4 mothers reported this attendance level for all their children and 4 for some of their children. A further 21 mothers (40%) reported their children attended almost all of the time; 19 mothers reported this attendance level for all their children; 2 for some of their children; two mothers (4%) indicated their children attended none of the time while one indicated the child had just started school. The attendance level for individual children, based on mothers reports, is outlined in Table 7.4 .

Table 7.4 Individual children's school attendance record in the recent past

Attendance level	Past year N (%)	Past month N (%)
Almost every day	33 (64)	38 (73)
More than 50% of the time	3 (6)	2 (4)
Less than 50% of the time	9 (17)	4 (8)
Not at all	7 (13)	8 (15)
Total	**52**	**52**

Most children (81%) attended the same school in the previous 2 years 15% had attended 2 schools, 4% had attended three or more schools and four children (aged 16, 14, 11 and 9 years) had not attended school in the previous 2 years. A total of 8% of children of women in these challenging accommodation circumstances have not been to school in two years; a clear marker of possible continuation of disadvantage into the next generation.[119]

The cost of shoes, clothing and the '*..extras that the other kids have in school*' was an added burden to many of the women, who felt their children could be 'marked out' and embarrassed by their status as poor and homeless in school. One women explained how, to keep her teenage daughter in the school she had attended all her life, she was now paying nearly £6.00 per day bus fare so that the child could travel to school from the homeless accommodation now provided for them – 15 miles from their original home from which they had been evicted.

Health

Mothers were asked to provide information regarding the health of their children (under 18 years). Information about children in the care of their mothers was more complete than that for children who were being cared for elsewhere. Table 7.6 provides mothers summaries of the current health status of their children. Where known, most children (56%) were rated as having very good or excellent health. Perhaps more notably 15% of mothers were not in a position to evaluate the health of their children .

Table 7.6 Child's health status as perceived by mother, by location of child's home

Mother's perception of child's current health status	Not living with mother N (%)	Living with mother N (%)	All children N (%)
Excellent	14 (17)	18 (2)	32 (18)
Very good	12 (14)	29 (32)	41 (24)
Good	16 (19)	36 (40)	52 (30)
Fair	4 (5)	4 (4)	8 (5)
Poor	2 (2)	3 (3)	5 (3)
Missing data /unknown	35 (42)	35 (20)	
Total	**83**	**90**	**173**

Maternal reports of children's immunisation and vaccination status is presented in Table 7.7. Uptake rates for vaccination programs are a cause for concern, particularly for children living in conditions that may expose them to greater risk of infectious diseases. Whereas the target rate for uptake of the Department of Health and Children's (DOHC) vaccination programme is 95%, about 80% uptake is achieved nationally (DOHC statistics). Even by self-report, only about half of the children in this study have been fully vaccinated. This is marginally better than the 44% rate in the Focus Ireland pilot study [12] but demonstrates the scale of the problem for this important service. It should be noted that children living with their homeless mothers are more likely to be vaccinated than children who are not with their mothers. The rate of 81% reported as having had all their vaccinations compares with an 85% national average, which although unsatisfactory (the target rate is 95%) speaks highly of the efforts made by mothers in challenging circumstances to engage in good health-seeking behaviours regarding their children.

Table 7.7 Mothers' *reporting of childhood immunisation & vaccination programme*

Vaccination status	Children living with their mothers N (%)	Children not living with their mothers N (%)	All Children N (%)
All vaccinations received	72 (81)	22 (27)	94 (54)
Some vaccinations received	9 (10)	7 (8)	16 (9)
No vaccinations received	4 (4)	4 (5)	8 (5)
Missing data or unknown	5 (5)	50 (60)	55 (32)
Total	90 (100)	83 (100)	173 (100)

While mothers reported that most children (for whom information is available; N=138) are healthy, a number of health problems were reported (Table 7.8) and treatment use was outlined (Table 7.9). At least one health problem was reported for 58 children (42%); some children had multiple problems. It should be noted that most interviews were conducted during the summer months and many mothers remarked on the seasonal variations in their children's health much of which they ascribed to being outdoors in favourable weather conditions – their children being healthier in summertime.

Table 7.8 Health problems of homeless children

Type of problem	N (%)
Asthma	25 (18)
Other chest complaints	5 (4)
Skin problem	4 (3)
Bone / joint problems	4 (3)
Psychiatric problems	6 (4)
Recurrent head lice	25 (18)
Injuries resulting for severe trauma	8 (6)

The following were health problems of single individual children: hole in the heart, hepatitis C, hydrocephalus, heroin addiction, attention deficit disorder, muscular dystrophy, eating disorder, premature infant (30 weeks), ovarian cysts, metabolic disorder, severe head injury.

Table 7.9 Aspects of children's health reported by mothers

	Children N (%)
Had an accident requiring hospitalisation	12 (7%)
Having on-going counselling	9 (5%)
Having at least one health problem requiring treatment	58 (34%)
Getting treatment for at least one health problem	49 (28%)

One child was currently in hospital as a result of trauma sustained through physical abuse by his father; another infant is in hospital recovering from injuries sustained in-utero as a consequence of trauma sustained by his mother in the context of 'domestic violence'. Children experiencing psychiatric problems include one child taken by his father to accompany him on his (the father's) suicide. Another child's disorder is understood by his mother to be related to bullying and physical abuse in a hostel for the homeless.

Use of health services

General practice (GP) services

In the previous 6 months, GP services were accessed for one or more of their children by almost two thirds of those mothers (N=32; 60%) who are the primary carers of all or some of their children. This compares with 41% of homeless children in the Focus Ireland pilot [121] The majority of visits were for chest infections (39%), followed by skin complaints (36%). Other complaints included recurrent gastro-enteritis, head-lice and other infections (ear, throat etc). The average number of visits per family for one or more children was 3.6 (SD: 4.1; median 2; range 1-20).

Accident and Emergency (A&E) services

Sixteen of the women (29% of primary carers) had been to the A&E Department in the previous 6 months with one or more of their children. This compares with 27% of the children in the Focus Ireland pilot study. [121] Twelve families had visited once, one twice, one three times and two families had visited five times each – the first for repeated instances of self harm by one child, the second because of one child's recurrent asthma attacks.

Out-patient department services

Eleven mothers (20% of the primary carers), had taken one or more of their children to an out-patients department in the previous 6 months. Eight families had had one to two visits, with three families having between three and eight visits each. Most visits were follow-up ones relating to medical or surgical treatment in the recent past; one was for psychiatric treatment.

In-patient hospital stay

Of the 90 children living with their mother, 9 had been an in-patient in hospital, for between one and 14 nights, in the previous twelve month period. One child, aged 13, had been admitted for attempted suicide. The remainder were receiving treatment for a variety of medical and surgical complaints.

Physical abuse of children

Seven women said their children had experienced severe physical abuse, five of these before becoming homeless. Two said their children experienced the abuse as a result of becoming homeless – one in a hostel for homeless people and one by the 'carers' in a State-run institution.

Sexual abuse of children

Eight (9.7%) of the 82 mothers knew or strongly suspected that their child(ren) had been sexually abused – two subsequent to their becoming homeless. Six of these women (75%) had become homeless as a consequence of removing their child(ren) from the abusive situation. Thus homelessness may be a consequence of some mothers trying to find a safer place for children than their own homes. Data presented below in point form combines information from open questions with quantitative analysis.

- One homeless woman put her child into care because she felt the environment in the B&B was unsuitable for her child. Now she strongly suspects that her child was sexually and physically abused while in care. Another woman placed her child in care for 'safe-keeping' (the family home had been the place of another of her children's sexually abuse). She suspects the child was subsequently sexually abused in care, by a carer.

- The information available indicates that those who sexually abused the children were in four cases family or surrogate family members and in two cases, carers as described above. There was one incidence of gang rape of a 14 year old child by neighbourhood youths and one case where a trusted neighbour was the abuser.

- The abusers in the family were, in one case, the child's natural father; one case of a surrogate fathers; one of a grandfather and one of an uncle to the children concerned.

- One child had been severely sexually abused, along with his sister, by their biological father and subsequently he experienced severe physical abuse by his step-father.

Mothers seeking help for sexual abuse of their children

All the mothers who reported their children had experienced sexual abuse had reported the problem and sought help[1] , although one women had delayed seeking help because she feared "... *the children would be taken from me*". The help they received was usually of more than one form and can be categorised as follows: medical help, help from legal/justice system, counselling and social worker intervention. Six of the women found the help they received satisfactory while two did not (one of these reported that she had her children 'taken from her' by the social worker).

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[1] Note that the women were cautioned that reports of previously unreported abuse would be passed on to the authorities as part of a good practice protocol by the researchers. The lack of reporting must be considered in this context.

Chapter 8

DISCUSSION

The study population profile reflected the 2:1 distribution estimated by the Homeless Persons Unit of B&B to hostel dwellers among homeless. However the lack of participation of one of the hostels, with the largest (and anecdotally the most 'difficult' or deprived) population was unfortunate. Their absence, alongside the absence of those 'sleeping rough', estimated at about 40 women [16], may mean that the results do not reflect the details of the lives of what are likely to be the most vulnerable women. Low response rates among some of those targeted may indicate that lack of willingness of the private establishment owners or caretakers to co-operate; it may also reflect low level of morale and motivation among the most depressed sections of this vulnerable group.

It is reasonable to expect services paid for or subsidised by public funds be responsive to research that aims to inform the service providers and policy makers. Refusal or reluctance to facilitate health research for service planning among residents paid for by public funds reflects poorly on the accountability of services provided by the private sector. In light of commitments contained in the new action plan outlined in Shaping the Future[149] it is hoped that the issue will be addressed by the appropriate agencies.

Demographic profile

The demographic profile of women in this study reflect the findings in a review of homelessness among women [121] in that they are mainly young (under the age of 35) mothers with a background rooted in poverty and social deprivation. That their numbers are increasing [18,19] in an era of unprecedented economic boom [123] warrants serious and urgent consideration. The literacy problems reported by more than 20% of the sample and the low levels of educational achievement suggest that the problems of accessing and negotiating services may be more difficult for what are already a vulnerable group. A recent study indicates that programmes providing homeless people with employable skills warrant closer examination.[124] The results of our study indicated that while the majority are without current employment, most of the women have undergone some training and work is reported as an important life domain (see Chapter 5, figure 5.6) by the group. Providing these women with practical support – suitable accommodation and childcare for instance – may enable them to become productive part of the workforce – particularly relevant given the current climate of labour shortage.

While the majority were unmarried, only a minority of those who did marry remain so, and the majority of mothers were caring for some or all of their children alone, in the most challenging of circumstances. This has implications for the range of social supports available to these women and makes them an important group on which to focus appropriate health and social strategies. Many of the problems identified among these women are acknowledged in 'Shaping the future'[149], and commitments to education and training contained in the report are welcome. However without a parallel commitment to support for childcare for these women, many homeless mothers would find it impossible to take advantage of opportunities presented.

Homelessness profile

Although most of the women had been homeless for more than a year, the majority did not choose to describe themselves as permanently homeless. The majority reported having been in similar-type accommodation, for up to a year – mostly B&B. This was not a source of comfort to the women but rather one of frustration due to the unsuitable nature of the accommodation in particular for mothers with young children. B&Bs, by definition, provide no service other than short-term accommodation. Yet this was also the most common type of accommodation used by the women over the previous 5 years. Restricted rights of access, cramped conditions, lack of facilities for food preparation and laundry as reported by the women indicate the unsuitable nature of the accommodation in which homeless families lived and in which mothers cared for their children. It should be noted that since the survey was conducted, the service contract with the providers of B&B accommodation for homeless persons has been renegotiated to provide for full-time access for residents. *Shaping the Future* [149] reiterates the short-term, emergency nature this type of accommodation. While remaining indoors in such an environment is not the desired outcome, measures that eliminate the hardship caused to the by vacating rules and allow homeless women a greater degree of control over their day-to-day routine are very much to be welcomed.

The children were at risk due to lack of safe play areas and generally unsafe conditions. These findings are confirmed in a recent report by Focus Ireland [125] on the unsuitability of B&B placements for homeless families. The stress engendered by lack of support in this type of accommodation and the sense of isolation experienced, was reported by mothers as having a negative impact on their ability to cope.

State agencies and homeless organisations acknowledge B&Bs as unsuited to the needs of those using them.[125,126] The providers are in the private sector whose remit does not include provision of the type of supports needed by this distressed and vulnerable group. In 1990, five families had been placed by the Homeless Persons Unit (HPU) in B&Bs at cost of £540; by 1999 the HPU had placed 1,202 households (individuals or family units) in these establishments, at a cost of £4.7 million.[125] This study documents the manner in which health and is compromised by these conditions; they lend weight to the call for alternatives to the current arrangements. The commitment in *Shaping the future* [149]that this type of accommodation will be used as a short-term, emergency strategy only is welcome.

It is noteworthy that 47% of the women interviewed also reported 'sleeping rough' in the last 5 years; this is reflected in the rise in this phenomenon observed over recent years in a recent report by Dublin Simon [19]. 'Shaping the future'[149] is committed to increasing the number of places in emergency accommodation and transitional housing, as well as planning for long-term accommodation needs. This is to be welcomed. Accommodation shortages experienced more widely – the 45,000 plus people on the local authorities waiting lists – will need to be tackled with similar commitment from a range of agencies if housing provisions for today's homeless people are not just to leave vacancies being continually filled by others in vulnerable accommodation situations.

A key objective of *'Shaping the Future'*[149] is to complete a review of emergency accommodation. The report questions whether private leasing arrangements are cost effective and responsive to the needs of homeless people. Although a cost benefit-analysis was beyond the brief of this research, evidence from the study showed that private leasing has meant that the families have a roof over their heads, but needs beyond this are not met, and in many cases these accommodation constraints are part of the ongoing problem for homeless women and their children. Given the range of challenges experienced by these women, in terms of their background and current

resources, a means to deliver targeted advice and interventions is needed. The supports provided for study participants housed in the NRHB hostel (targeted at the type of problems these women experience), are deserving of focussed consideration by future accommodation planners.

Reasons for becoming homelessness

Discussions about the causes of homelessness in the literature have pitted structural and systemic variables against individual level characteristics, sharply polarising the issues.[127-130]The question of why homelessness exists as a major social problem has been confused with the question of who is likely to become homeless. Factors that compromise an individual's economic and social resources are associated with greater risk of losing one's home [131] and the findings reflect this observation. Relative poverty in Ireland has increased [123] and we found the most frequently quoted reason for becoming homeless by respondents in this study was the inability to find affordable accommodation. These findings are echoed by Sr. Stanislaus Kennedy, president of Focus Ireland who stated that "families who were self-reliant were being pushed into homelessness because of a lack of affordable or social housing". They were, she proposed, "the victims of the economic prosperity and the housing crisis in this country."[132] The physical and sexual abuse of women is perhaps the clearest marker of their vulnerable social position. [133] The numbers of respondents who reported domestic violence and removing themselves and / or their children from abusive situations as precipitating their entry into homelessness reflects this phenomenon. It provides an insight into why some women 'choose' to stay in violent or abusive relationships – the only option it appears, for some, is homelessness.

Heroin addiction, the chaotic lifestyle associated with its use, and the link with homelessness is well documented in the literature [30,41,46,125] It was cited by a significant minority of respondents as the reason for their entry into homelessness. A number of cases illustrated what is perhaps a tragic irony; that some strategies introduced to deal with the problem of heroin addiction have made matters worse. Dublin Simon, commenting on measures taken by Dublin Corporation whereby drug users (and others) may be evicted from public housing, summarised this view: "..by excluding the whole household rather than the offending individual in the household, considerably more individuals have been evicted than official numbers would suggest." [19]

Early life experiences have been associated with vulnerability in adulthood, including vulnerability to homelessness[119] and the findings indicate the majority have histories of circumstances that have contributed to their disadvantage in adulthood. For a significant minority, their entry into homelessness was as children or adolescents; a group which a recent report suggests may fail to receive the appropriate interventions and service from the agencies designed to provide them. [134] Coping skills are stretched by the circumstances of homelessness and early life experiences, psychological distress and addiction problems may increase the challenges faced by these women. Peer support and education programmes (by formerly homeless women), similar to the Community Mothers Programme[151] could be used to inform and support homeless women in accessing services and negotiating health care and service options.

The small minority who suggested mental health problems as a reason for their homelessness reflect the views of a study that argues that mental health problems are not a primary contributor to homelessness. Fernandez states "Regrettably, some politicians view homelessness as a psychiatric problem rather than a consequence of policies that marginalise people and exclude the poor from housing." [135] However, it may also reflect a low uptake of participation in the study by women whose psychological disorder make it difficult for them to indicate willingness to participate.

Smoking

The group report one of the highest levels of smoking among any population. The difference in prevalence of smoking between homeless women and the general population SLÁN Survey[87] emphasises clearly the greater health risks experienced by this group as a result of this risk factor and confirms Graham's findings[65] of smoking as a coping mechanism used by mothers living in isolation and poverty. Although the majority expressed a wish to quit smoking 'at some point in the future', only 2% intended trying in the next 12 months. Taken with the high levels of psychological distress reported among this group, it is unlikely that smoking cessation programmes would succeed at this time, but may be of benefit to individuals once basic housing and other needs are met. Smoking cessation supports such as one-to-one brief intervention counselling and smoking cessation clinics may help these women to quit at some point in the future and could thereby lead to a reduction in morbidity and mortality from smoking-related diseases among them, and reduce related risks for their children.

Alcohol and drug abuse

The use and misuse of alcohol was low by comparison with Irish norms in the SLÁN survey, and in comparison with homeless men in the Feeney et al study but high by comparison with homeless persons in the British OPCS figures. The low levels of alcohol use and consumption may reflect their inability to afford to drink as they might wish. It may also be a reflection of the difficulties unsupported mothers have in accessing social outlets; so many of which in the Irish culture are alcohol-centred. All measures of illicit drug use were high by comparison with the British OPCS data and with homeless Irish men in the Feeney et al study. The levels of opiate addiction in particular reflected the youth and background of the sample. Heroin addiction in Dublin has been described as a "bush fire" showing a sudden and rapid spread among socially and economically deprived youth, in the recent past. Homeless Irish women as represented in this study are in the main younger women - a different generation to most of the men in the Feeney et al study.

That such a high proportion sought and / or were availing of treatment for their addiction, endorses a view expressed by the authors of a review of the literature relating to psychiatric co-morbidity among the opioid dependant. They suggest "that it is not heavy drug use alone that motivates opioid users to seek out treatment but personal problems such as depression and legal and social problems" .[136] Whatever the principal motivating factors are, it is an indication of the essential role of drug treatment services. Delays for those seeking treatment for addiction problems, reported by one respondent – a young mother caring for her child as a lone parent – are not acceptable. For many women, access to a doctor or counsellor for problems not directly related to their addiction, has been through the drug treatment services. This has implications for routes through which to direct needed services, from health promotion to life skills and educational programmes. It also indicates the burden carried by this service, beyond its core function and suggests the need for to evaluate the resources needed to provide these additional services.

Moreover, the difficulties of trying to cope with addiction while also dealing with the stresses of homelessness must also be borne in mind by the service providers. Adherence to treatment may be compromised by the stresses experienced in being homeless. Housing policies that seek to support rather than punish those with addiction problems would seem to have the potential to tackle two social problems at once – homelessness and heroin addiction.

High-risk behaviours associated with intravenous drug use were confirmed in the hepatitis C levels reported among this group, and indicate a worrying ignorance of, or indifference to, 'safe' drug-using practices. Health promotion and advice about service availability may need to be channelled in novel ways for these very marginalised women, some with literacy problems, alongside all their other difficulties. Projects such as those involving Big Issue vendors as peer educators in the UK147 may provide innovative models of how to reach this group.

Physical health

Disability in the Irish population as a whole stands at 10% [138] and is reflected in this relatively young sample, with 11% of respondents registered as disabled. The experience of being disabled presents varying degrees of difficulty – that these should be borne in a homeless state suggests an urgent need for the relevant support agencies to address the issue of homelessness.

While the pattern of illnesses and health complaints identified in the current study was similar to that seen in previous work among homeless people in Dublin, [16,98] women in the sample reported greater levels of morbidity for both physical and mental health than other groups for whom comparisons are appropriate. More than half of these women were caring for young children; eleven percent were disabled. These facts lend weight to a call for urgent support and treatment for homeless women.

The prevalence of hepatitis C has implications for health needs for the future for these women and the welfare of dependant children. Complex treatment regimes for hepatitis C require debate among service providers. A study among active or former heroin users was conducted in the setting of general practice in the EHRA[150]. Similar to this sample of homeless women, around half of the population of drug users were HCV positive, more than a third of whom had been referred to a specialist hepatology unit.

Gynaecological and obstetric screening measures have failed to reach a high proportion of this vulnerable group. Only 43% had had a cervical smear test. This compares with 50% who report ever having a smear test among a group of women from a socially deprived background in Dublin. [119]. The findings lend weight to the call for strategies like specific outreach programmes or opportunistic interventions. Although these women were high service users - discussed below - there remains a very high level of unmet need for treatment for both physical and mental health problems. Reasons for this require further study, but meantime strategies are required which take account of the particularly challenging circumstances in which these women find themselves. Outreach, fast tracking, opportunistic interventions and crisis intervention teams are methods which may be appropriate to meeting both chronic and acute needs.

There was a high pregnancy rate of 11% rising to 19% in the under 25 year olds. Pregnant homeless women pose a unique challenge to the health care delivery system because of the high-risk nature of their pregnancies and the conditions in which they live. They lack stable accommodation and social support, have poor nutritional status, high smoking levels, physical and mental illness health and addiction problems – observations well documented in the literature [48] and confirmed among the sample. Temporary accommodation and homelessness during pregnancy have been shown to be associated with more antenatal and delivery problems [49,50]. Although all the women pregnant in the study were receiving ante-natal care, among all mothers in the group, the history of 39% failing to access adequate post-natal care is alarming, and does not auger well for these women or their infants.

Psychological well-being and quality of life

In terms of subjective mental health status measures (GHQ and SF-12), as well as reported disease and symptoms levels, the sample were the most distressed group of any comparable population. Homeless women are known to experience high rates of psychiatric morbidity [139] in particular, homeless mothers.[140] The findings of this study confirm that the women caring for children have a higher prevalence of psychiatric morbidity in terms of GHQ casesness, though the difference between them and the women not caring for children was not statistically significant. A recent longitudinal study among homeless people in America looked at psychological distress and methods of alleviating it. Not surprisingly, reduction in distress was associated with the provision of appropriate resources in terms of housing.[141]

Tangible measures of social support are poor for all the women, but particularly so for mothers caring for their children. The implications for the welfare of not only these women but also for the children in their care, are as alarming as they are tragic. The potential for self-harm, or for mistreatment of children, must be borne in mind in such trying and isolated circumstances, and supports the call for crisis intervention.

It is of interest that although high levels of physical health problems were reported in terms of disease and symptoms, the subjective health status measure (SF-12) indicated physical health status among the group comparable to Irish population norms, but mental health status five times poorer than the norm. The explanation for apparent discrepancies in terms of physical health measured by the SF-12 and the factors outlined in Table 5.1, may lie in the fact that the SF-12 does not enquire into the presence of actual disease or symptoms, but rather the physical effects on day-to-day living. It may be that these women 'get on with it', not because their physical health problems are not real, but because they cannot afford the luxury of abstaining from routine tasks despite their ill-health.

The combination of the impact of physical and psychological factors, may perhaps be best judged by the measure of their quality of life. The SEIQoL-DW scores for the sample indicated the poorest quality of life among any group with whom it was possible to draw comparisons, including people who were terminally ill.

Use of health services

Confusion remains in the area of GMS entitlement and access and requires attention. GMS status – having a medical card – is a measure of access, as well as route of access, to health and related services. It is of concern therefore that a significant minority of highly disadvantaged women were not served by this system. The unmet need for contraceptive and other well-woman services through the GMS scheme for a minority of the women, is a reflection of similar findings regarding these services for housed women[116-118], but taken together with the other challenges in their lives, may have a more serious impact. Some women who did not have a medical card could access free health care through their drug treatment service, or through a special 'group cover' arrangement through the Northern Area Health Board (NAHB) run hostel. These systems appear to serve the women well, but may break down with a loss of continuity in their status with these services. There is also a need for GMS cover for mothers in particular, outside of the setting of drug treatment services. Of the 55 mothers whose children live with them, only 37 (67%) have 'their own' medical card. The minority who reported problems in getting a card, applying or finding a willing GP, clearly need support in overcoming their difficulty.

GP services were used less by non-medical card holders and by those with mental health problems, which means a significant minority, perhaps the most needy, lack access to primary care and other services which require access

through it. This also has implications for use of other services, particularly the hard-pressed A&E services which, the findings illustrate, may be used instead of a GP by those without ready access to one.
Studies elsewhere show that the homeless population have high levels of service use. [89] Comparisons in an Irish setting are difficult given the dearth of information on population norms. Service use reviewed in this study indicated rates similar to homeless men in the Feeney et al study[98]. Given the high morbidity rates among the group for both physical and mental health, high service use is not unexpected. Hospital admissions appear high compared with a study of homeless persons in one London borough [6] which showed 26% of the adult homeless had been admitted to hospital, compared with 41% of the women in the sample.

Physical violence

Figures indicating serious violence in this group of women show a pattern similar to that found in the international literature. [32] Levels were more than three times the rate for Irish women in general [142] and with higher degrees of severity and resulting injury; more than 5 times the injury rate in one Irish study [143]. While comparisons with general population rates are hampered by lack of uniform measures, the scale of the difference makes it reasonable to assume that homeless women are among the most brutalised in Irish society. The majority report first experiencing violence in childhood. Most of these women went on to experience violence from their adult partners in their own homes–, many of whom only escaped the violent behaviour by becoming homeless. The majority of those who had experienced violence from an intimate acknowledged the fact to a doctor. This reflects the finding of a recent Irish study that poorer women are more likely to acknowledge the experience than others.[144] This may make identification of the problem easier among homeless women and may facilitate early intervention by medical services. Although some women experienced violence while homeless, the pattern was not so much of homelessness leading to violence against women, but of violence against women leading to homelessness. More than half the women sought help but for many seeking help was delayed, often because of fear or misplaced hope in their own ability to 'sort it out'. While most of these women in the study were now removed from the abusive situation, they still lacked a safe and suitable environment in which they might live without violence, and a minority were being pursued by their former abuser in their homeless state.

Sexual violence

Almost half the sample experienced violence and abuse of a sexual nature, the majority for whom the abuse included rape. For most of the victims, their first experience of sexual violence was in childhood – most commonly the perpetrator was within the family. Disclosure was in most cases delayed - into adulthood for many, usually through fear or ignorance - echoing a trend established in the literature[122]. As with physical violence, leaving home was the only route of escape for some, even though this led to a precarious existence and ultimately to homelessness. Many of those experiencing sexual violence were also victims of physical violence. It is perhaps in this context that high levels of drug use and depression may best be understood; the international literature is rich in studies documenting these associations. [136,145] The pattern was not one of homeless women being abused by anonymous strangers, but of females abused since childhood - the impact of which has contributed to their homeless state. That many are still experiencing difficulty in accessing appropriate counselling services is of grave concern.

The service implications of these findings need to be addressed if outreach and other approaches are to meet the needs of these women who face risks of abuse and challenges of dealing with the aftermath of abuse, in an already compromising set of life circumstances. As the CHAR [142] report in the UK suggested, the needs of those recovering from sexual abuse 'sit uncomfortably with the pressure on resources for all homeless people'. There is a concern that already stretched services are unable to provide the specialist care needed to address such specific and sensitive concerns regarding abuse. 'Shaping the future'[149] commits to the provision of easy access to counselling for homeless people. This is to be welcomed. The profile of counselling issues identified here, e.g. physical and sexual abuse and heroin use, signals the complexity and challenges of providing appropriate and sufficient services for this group.

Children

Half of the children of homeless mothers in this study were living with their mothers in accommodation unsuitable for child rearing. They lacked access to appropriate cooking facilities and safe play areas. Their mothers' distress, lack of support and reported ability to cope is a source of grave concern, as are histories of violence and sexual abuse experienced by a significant minority of these children. 'Shaping the future'[149] proposes to develop day centres for homeless people. This welcome commitment must take into account the fact that 'day-care' facilities will need to be provided for children as well as adults and will need to cater for children across the full age range to end of secondary school level.

Comparisons with Irish children generally are difficult (because of the absence of overall national data) but figures indicating 10% in-patient hospital care in the past 12 months appear very high. Combined with information on the variable level of school attendance of these children, it suggests a substantial group of children whose health and education is challenged by the living circumstances of their mothers. The findings mirror those in international studies [146] which underline the impact of homelessness not only on childhood but on the developing adult. Health and education are their resources for the future. As the authors of a recent report say "There is a social and economic cost to society when children are born in the poorest circumstances"[146]. That the majority of children attend school regularly is both remarkable and praiseworthy, given the range of problems day-to-day living presents for their mothers. The authors suggest that the percentage that continue in school and attend regularly, is more impressive that the percentage that do not.

CONCLUSIONS

Homeless women in this study were mostly young mothers with a multiplicity of health and social problems and living in difficult circumstances in which they experienced isolation and inadequate support. They appear poorly served by the ad hoc development of emergency accommodation provision in the private sector – the accommodation in which most homeless women live.

Inability to access affordable housing was the main reason reported by the sample as a reason for their homelessness. Most were experiencing homelessness for the first time. Most considered it temporary though just over half had been homeless on this occasion for more that a year. Their background is poverty; many had experienced difficult early life challenges with low educational achievements and literacy problems for a minority. Work was important to them and many have had training through the FÁS agency. However most were unemployed.

They had more physical health problems and experience greater levels of psychological distress than any comparable group. They also had high levels of unmet health need despite frequent contact with services. Eleven percent were disabled and a further 11% were pregnant.

They smoked more and drank less alcohol than homeless men and the general Irish female population. Half had opiate addiction problems, most of which were being managed by drug treatment services.

Half the sample had experienced serious physical and sexual violence, many since childhood and in the context of their family. The abuses they experienced were, for the vast majority, before they became homeless. For many abuse was a significant contributor to their homelessness. The needs of this vulnerable group for access to appropriate counselling and related services have not been met.

Most homeless mothers were caring for some or all of their children. Their welfare was compromised by the living conditions of their mothers. These children lacked access to important resources such as appropriate cooking facilities and play areas. They appeared to have high levels of ill health and services use, though without norms comparisons are unreliable. Low vaccination rates and incomplete school attendance were a further cause for concern. That the percentage of children attending school regularly is greater than the percentage who do not, is a testimony to mothers caring for children in the most challenging circumstances. Removing their children from a sexually abusive situation was the factor which propelled a minority of mothers into homelessness.

RECOMMENDATIONS

PREVENTION

- Strategic planning for affordable housing, appropriate to the needs of both families and single people, is essential if the problem of homelessness, both present and future, is to be meaningfully addressed. Plans outlined by the Homeless Agency their new report *Shaping the Future* require urgent implementation and must not be jeopardised by housing shortages more generally. Lack of affordable housing and other factors contributing to poverty in Irish society must be addressed if increasing levels of homelessness are to be avoided.

ACCOMMODATION

- The interim situation requires an urgent response from statutory agencies. Publicly funded, accountable and professionally staffed or inspected support accommodation should be made available. The NAHB run hostel provides a working model of how short-term emergency accommodation could be structured. The knowledge and experience of staff in such services can also inform the planning and provision of transitional accommodation. Commitments to the use of B&B establishments in *Shaping the Future*[149] as an emergency and short-term response only, must be honoured.

SERVICE NEEDS

- The GMS medical card application process for homeless people should be made more accessible. This should involve education of homeless women and staff with whom they have contact, about entitlements and application procedures. Contacts with the health services should be used as opportunities to determine medical card status and to facilitate the application process where appropriate. The 'Action Plan' of the EHRA related to homeless persons, has a brief to provide fast-tracking for GMS application; this must be promoted by all agencies dealing with homeless people.

- The needs of homeless women with psychological disorders require focused consideration of how, where and by whom, services can be effectively delivered. Specialised counselling services for those who have been abused, or have substance abuse problems could provide a fast track route for these women already facing the difficulties of basic day to-day-living. Consideration should be given to the role of newly appointed counsellors for homeless persons in terms of advocacy for rapid access and 'referring-on' to more specialised services (e.g. physical or sexual abuse, or drugs related counselling) for their clients.

- Strategies for the provision of childcare facilities for homeless mothers should be considered. Support in this essential area would enable them to take up employment, education and training opportunities. This would bring a much needed quality to the lives of mothers who survive on the margins of society in such adverse circumstances. Responses to the needs of children based in emergency accommodation for safe play areas should include consideration of the range of ages to be facilitated. Play groups, mobile 'play-buses', outings etc. should be organised in ways that can be easily accessed by families housed in a number of different locations around the city.

- Peer support and education programmes (by formerly homeless women), similar to the Community Mothers Programme, could be used to inform and support homeless women in accessing services and negotiating health care and service options. Such programmes should be put in place in the short-term, as well as receiving attention for strategic planning where long-term support is necessary.

SERVICE PROVISION

- Urgent attention should focus on the most extreme cases of distress among mothers in particular with a view to immediate crisis intervention. The new multidisciplinary teams and outreach services for the Homeless Persons Unit, proposed in *'Shaping the Future'*, should co-operate in devising strategies for identification and intervention for cases of severe distress and extreme need. Two new ERHA services just started will provide outreach facilities and have a presence in B&B and hostel accommodation . These are a welcome development.
- Outreach services may provide a mechanism through which health screening and promotion could be delivered.
- Opportunistic interventions addressing unmet need for treatment of physical health problems should be promoted among those with whom homeless women have professional contact.
- There is a need to evaluate the role played by drug treatment services in the lives of homeless women. It appears that for many women, access to a GP, to counselling services, to training and educational opportunities and to social worker services are accessed through their drugs treatment centre. Consideration should be given to providing appropriate support for drugs treatment services in their 'extended' role.
- The response to psychiatric services and counselling services is considered in *Shaping the future*. The challenges for a specialised counsellor for homeless persons must include consideration of the role as the access point to services for homeless people. Consideration should be given to their function in 'referring on', if more specialist (e.g. physical and sexual abuse, drug-related) counselling service are required.

ORGANISATIONAL NEEDS

- There is a need for consultation among health and other professionals who deal with homeless women, addressing the question of how best to structure the required services.
- There is a need to develop links between GPs and other primary care professionals, health boards and voluntary agencies. The North and South Inner City GP Partnerships, the GP Unit and the Homeless Agency are in a position to facilitate these links, and movement in this direction has commenced This will help to integrate the provision of health services with the other services provided for homeless people, many of which, directly or indirectly, have an impact on health.
- Statutory agencies related to education and child welfare must be included in such consultations. The National Children's Office should co-ordinate strategies relating to homelessness and child welfare.
- New services (envisaged by the EHRA) – the multidisciplinary teams, and planners for the Homeless Persons Unit's outreach services – have the potential to ensure appropriate liaison and service delivery. The EHRA should take responsibility for co-ordinating these services.

CO-OPERATION AND PLANNING

The proposed introduction of co-ordinators for health and care services in each health board area as outlined by the Homeless Agency is both timely and welcome and some staff have already been allocated to these roles. Together with primary care teams (as outlined in the Eastern Health Board report entitled *Homelessness in the Eastern Health Board: Recommendations of a Multidisciplinary Group* (March 1999)), they can provide an important mechanism whereby the previous recommendations can be realised. These teams should at all times act as a support to primary health care services to facilitate the re-introduction of homeless people into mainstream services. Action plans of these teams can be informed by the findings of the present study. The teams should also consider mechanisms for providing a forum for the views of homeless women themselves.

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