

# Homelessness: An Unhealthy State

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**HEALTH STATUS, RISK BEHAVIOURS AND  
SERVICE UTILISATION AMONG  
HOMELESS PEOPLE IN TWO IRISH CITIES**

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*“I’m 13 years on a housing list.  
Being housed will improve my health.  
Instead I’m given the run around  
and pawned off.”*

**-33 year old homeless man  
(2013 survey)**

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# The Partnership for Health Equity

The Partnership for Health Equity (PHE) brings together researchers, educators, health planners and practitioners from HSE Social Inclusion and Primary Care directorates, University of Limerick (UL) and North Dublin City GP Training Programme (NDCGP). The PHE mission is to contribute to making health equity a reality through research, education, policy and practice. The PHE is co-funded by the HSE (Social Inclusion & Primary Care directorates) UL and NDCGP.

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O L L S C O I L L U I M N I G H



North Dublin City GP Training  
Health Care For All

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On behalf of the Partnership for Health Equity*

# Foreword

In 2014, a total of 4,976 adult individuals engaged with homeless services in the Dublin region. During the fourth quarter in 2014, 2,660 adult individuals accessed emergency accommodation in the Dublin region. The Rough Sleeper Count in November 2014 discovered a minimum of 168 adult individuals sleeping rough on the night of November 11th 2014. These very stark figures represent a significant increase on comparable figures for 2013 and paint a shocking picture of homelessness in major Irish cities.

Behind each statistic is a personal story, one of experiences that have a profound effect on the homeless person as well as on his or her family, friends and communities. Homeless people live on the margins of society, often invisible, without dignity or hope of a better future. It is clear that drastic measures must be taken to address this troubling situation. Exiting homelessness should be a treatment goal for all services working with homeless populations.

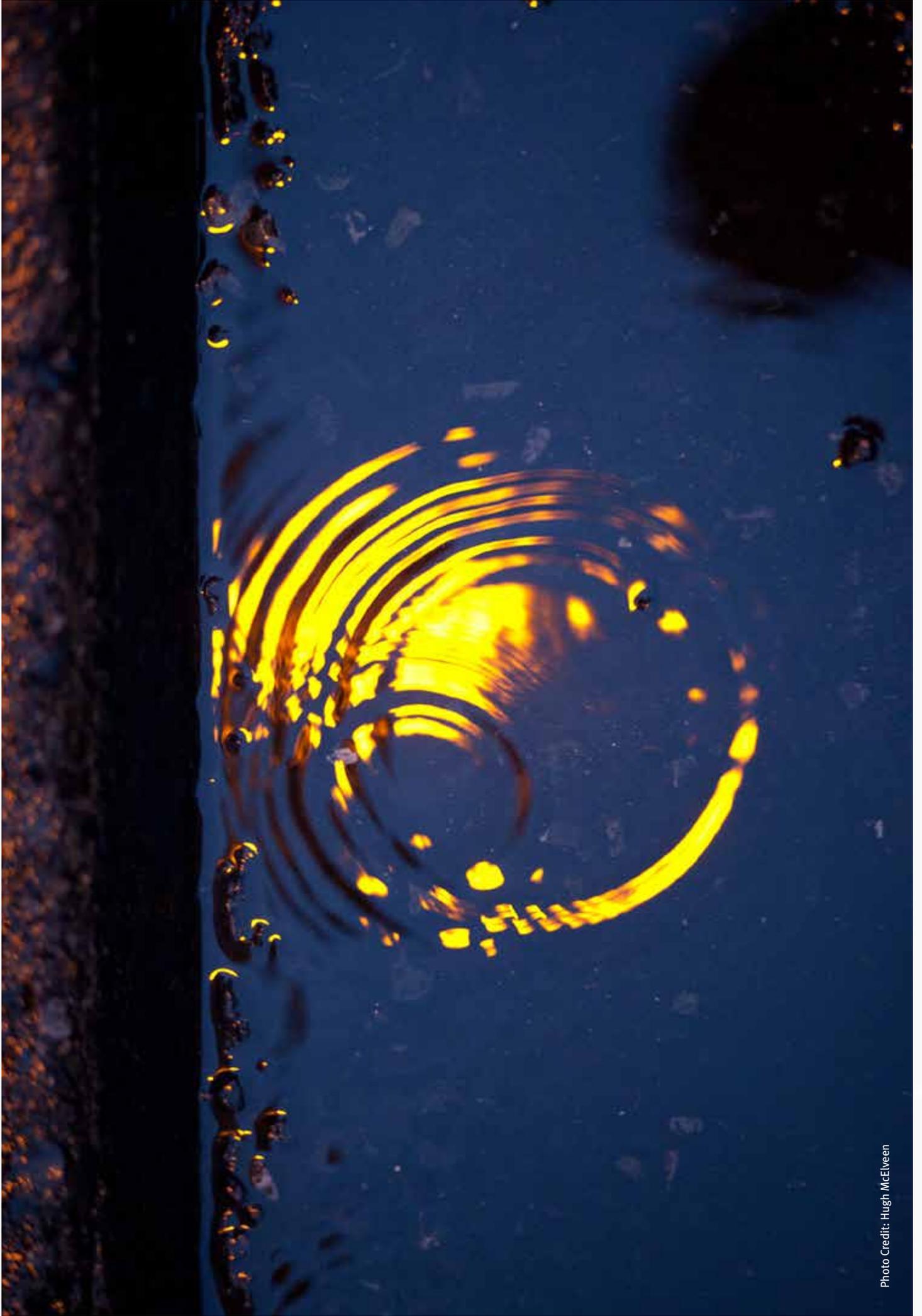
Homelessness is a deeply unhealthy state. There is little doubt that homeless people can face major barriers in accessing health services, while their circumstances can often mean they are among those most in need of treatment and care. Although we know that there is a clear link between homelessness and ill health, this report demonstrates the scale of ill health, particularly where the mental health needs of homeless people are concerned. That 1 in 3 homeless persons report having attempted suicide, that more than half have a diagnosed mental health condition and nearly all have either a mental or physical health condition is a clear confirmation of the burden of ill health experienced by this vulnerable group of service users.

The research informing this report is a unique undertaking of the Partnership in Health Equity. The HSE has supported the PHE – and forms an integral part of it - because of its innovative approach to addressing health inequities by bringing together a unique collaboration of clinicians, medical educators, social scientists and healthcare policy makers and planners to identify the health needs of vulnerable groups and inform appropriate solutions. It is apt therefore, that the PHE has chosen to start its work with the homeless population - arguably among the most vulnerable in our society. The findings point towards the need for strengthening and supporting a coherent approach that facilitates easy access to health services for homeless people, where possible linking in to mainstream services, and ultimately linking health care solutions with appropriate housing solutions. The interagency approach adopted to undertake this research offers an excellent model of collaborative working in an area where factors leading to homelessness are multifaceted and complex, and where ready solutions are not easily found.

I welcome the report and I am confident that its findings will point the way towards further proactive targeted interventions in the quest to combat homelessness. I confirm the commitment of the HSE to apply the findings of this report towards such actions.

**John Hennessy**

*National Director: Primary Care,  
Health Service Executive*



# Executive Summary

The link between homelessness and poor health is well established. Homeless people have much worse physical health than the general population and are much more likely than the general population to suffer mental health conditions. A review of the literature demonstrates higher mortality and health risk taking behaviour among homeless populations compared to housed populations (Bagget et al., 2010; Smith et al., 2001; Holohan, 1997; Herndon et al., 2003; Hwang et al., 2011; Beijer et al., 2011). Improving the health status and service usage of homeless people may lead to a reduction in their excessive suffering and may also help them to exit homelessness. Improvements in this area may also lead to a reduction in costs to the health services (Fuehrlein et al., 2014; Hwang et al., 2011).

In 1997, the first assessment of the health of the homeless population in Dublin was conducted (Holohan, 1997). This study was repeated 8 years later in 2005, to determine change and the impact of service development in the intervening years. Based on its findings, the repeat study recommended health service developments to target needs of the homeless population (O'Carroll & O'Reilly, 2008). Given the service development in the sector, the time lapse since the last study and the development of the economic crisis in the interim, the Partnership for Health Equity (PHE) decided to repeat the health survey in Dublin and to conduct a baseline survey in Limerick in the interest of planning and service development. The aim of the study was to assess the health status of the homeless populations of Dublin and Limerick cities and their access to and utilisation of health services. Trends in Dublin over time could be charted and a baseline against which to measure service change/development going forward could be established in Limerick.

## Study Design and Methods

A cross-sectional survey of homeless people in Dublin and Limerick cities was carried out during the second two weeks of September 2013. To be included in the study a homeless person had to be age 18 years or over and resident in Emergency Accommodation (EA), Supported Temporary Accommodation (STA), Private Emergency Accommodation (PEA) or sleeping rough, in Dublin and Limerick city during the period of study. The 2013 sample is representative of those staying in the targeted accommodations in Dublin and Limerick cities. The survey questionnaire was divided into four sections: demography and homelessness, addiction, health status and use of health services and took approximately twenty minutes to complete.

## Results

There was an overall response rate of 64% of those staying in the included accommodations (63 in Limerick and 515 in Dublin). A further 23 rough sleepers were included in Dublin giving an overall total of 601 respondents in Dublin and Limerick.

## Demographics

The results show a predominantly male, Irish, Roman Catholic homeless population. The majority of participants were aged under 45 years and single. The vast majority were unemployed and subsisted on social welfare payments. Family problems and drugs and alcohol addiction featured heavily as self-reported reasons for homelessness. Homelessness was often long-term; however, this was more likely in the Dublin sample. There was a disproportionate number of the sample who had been in care as a child, potentially indicating the importance of social supports in preventing vulnerability to homelessness.

## Addiction

Tobacco smoking has increased to become almost universal among this group. Reporting a history of illicit drug use has steadily risen since 1997. Results suggest that over time, addiction patterns among homeless people have changed to become largely poly substance abuse with much cannabis and minor tranquillizer abuse particularly among the younger cohort. Rates of dangerous drinking have also increased, particularly among women.

Findings in the area of addiction suggest a high level of poly drug misuse among homeless people and good treatment coverage in Dublin. However, there may be a need to increase methadone coverage among rough sleepers given the lower proportion on methadone. While there was an increase in treatment coverage in Dublin since the last survey, the structure of provision has not changed; the majority of homeless people still attend clinics for treatment rather than either mainstream primary care services or specialised health services for homeless people.<sup>1</sup> The majority of people on methadone reported also using illicit drugs including heroin. Alcohol use was more prevalent among the Limerick group and drug use was more prevalent among the Dublin group.

## Health

Mental and physical health problems can be both a cause and an outcome of homelessness. Almost the entire sample had either a diagnosed mental or physical health problem and the majority were also receiving treatment for ill health. Respondents tended to perceive their health negatively. The health issues experienced affected the daily activities of approximately half the sample. Mental health issues were very common, with over half reporting a diagnosis of depression. Almost half of the sample had both a mental health problem and an addiction problem.

Alarming, more than one third of the study population had self-harmed; three fifths have had suicidal thoughts and more than one third had attempted suicide. Half of those reporting a mental health diagnosis had attempted suicide. The connections found in this study between mental health problems and suicide are important; they point towards the complex interplay of mental health, homelessness and suicide. Addiction and the length of time spent homeless are both also factors associated with attempted suicide.

Drug and alcohol addiction and mental health issues present as the most pressing of health concerns and are associated with secondary health problems also found to be elevated among this population, such as liver disease, dental problems and Hepatitis C. Compared with the 1997 and 2005 studies, the homeless population has more diagnosed ill health, more are treated with prescribed medication, and more report mental health diagnoses and treatment.

## Health Services

Overall, there is a high level of health service utilisation with the vast majority of participants having seen a primary care GP or nurse in the previous six months. Half reported having attended specialised health services for homeless people. Medical card coverage has greatly improved over time and was higher in Limerick than in Dublin. The level of primary care use (whether specialised services or mainstream) has increased over time. Staying in Supported Temporary Accommodation (Dublin) or Emergency Accommodation (Limerick) was associated with better support to access health services and having a key worker. Having a key worker was positively associated with having a care plan, use of specialised health services, having a medical card and attending psychiatric services.

While the use of primary care services has increased, so too has the number of homeless people attending hospital emergency departments and being admitted. Compared to the previous studies there appears to be some reduction in use of psychiatric services including psychiatric hospital admission. Though this is in line with national policy that aims to reduce psychiatric inpatient admissions, the impact of such policies without the recommended crisis houses (Department of Health and Children [DOHC], 2006) requires further exploration in the context of the very vulnerable homeless people with mental health problems and suicidality found in this study.

Health service use and access appears to be greater in Limerick than Dublin with a higher use of mainstream services. This may simply be an effect of smaller more manageable numbers in Limerick.

<sup>1</sup> In Dublin these are Safetynet services and in Limerick outreach multidisciplinary health services to hostels.

## Recommendations

Specific recommendations are made to improve service coherence. This would be facilitated by the development of a national strategy for health care provision for homeless people aligned with government plans aimed at addressing homelessness. In addition, in Dublin due to the size of the homeless population and the number of services, the establishment of a special homeless health committee with representation from health, addiction, mental health and housing sectors, is necessary. The explicit aim of such a committee would be to improve service coherence from the users' perspective and to expedite exiting homelessness particularly for the chronically unwell.

Specific health service recommendations include expansion of specialised primary care services on site in homeless accommodations comprising a full primary care team with professional disciplines reflecting the needs of the particular population. Health promotion campaigns and interventions to target extremely high levels of smoking and dangerous drinking and to improve access to Hepatitis C treatment are needed. Vaccination campaigns and screening for specific conditions more prevalent in this population should be conducted routinely.

Specific recommendations are made to address the alarming rates of suicidality through the urgent establishment of a coherent and specific stepwise intervention for homeless people in crisis in line with national suicide prevention guidelines. A crisis house would be part of this intervention. A review of appropriate mental health supports and services (including non-medical) that are accessible to the homeless population is required. This should result in the development of clear accessible information for homeless people and those who work with them, on appropriate mental health interventions and services. Capacity needs to be increased within the homeless sector so that those with mental health problems and/or at risk of suicide are identified and provided with appropriate supports and services. This will require professional cadres equipped with specific skill sets to meet clients' needs on-site in homeless accommodations as well as the upskilling and training of key workers.

A specific recommendation relating to addiction services suggests a review of the structure of the provision of methadone treatment mainly through centralised treatment centres for this client group. Tighter controls on prescription of benzodiazepines are also recommended.

With regard to accommodation, provision of additional resources is required to ensure the Housing First model extends to support all chronically homeless people with multiple support needs. City and County Council accommodation for people with mental health needs is a priority in order to prevent the mentally ill becoming homeless. Supported Temporary Accommodation (STA) appears more favourable in terms of health care access than Private Emergency Accommodation (PEA).

Further research could usefully explore the following areas: i) the increase in A&E usage in the context of increased access to primary care ii) the impact of reducing inpatient psychiatric beds on the treatment of severe mental illness among the homeless iii) the difference in specific morbidities and multi-morbidities among homeless and housed populations iv) the health service blocks to appropriate care and treatment for homeless people and v) risk factors associated with suicidality among homeless people.

## Conclusion

Homelessness is an unhealthy state with homeless people suffering disproportionate levels of illness and addiction. Almost the entire sample had either a diagnosed mental or physical health problem with the majority receiving treatment for ill health. The findings from this study also show an increase in medical card coverage. Over half the Dublin sample and most of the Limerick sample reported visiting their own GP in the past six months. The increased use of primary care services in Dublin appears to have been facilitated by specialised services for homeless people.

Overall, the health needs of the homeless are great and though much has been done already to improve access and care, much more can be done, particularly in the area of mental health and addiction. Ultimately though, a move from the homeless situation will improve health and wellbeing.



Photo Credit: Hugh McElveen

# 1. Introduction

**The link between homelessness and poor health is well established. The literature demonstrates higher mortality and morbidity rates and health risk taking behaviour among homeless populations compared to the housed population.**

Despite the increased need for health care, studies have consistently demonstrated an under-utilisation of primary care services by homeless people while at the same time revealing high-attendance rates at secondary care services.

In 1997, the first assessment of the health of the homeless population in Dublin was conducted (Holohan, 1997). This study was repeated 8 years later in 2005, to determine change and the impact of service development in the intervening years. The repeat study showed a changing disease profile among the homeless population consistent with a growing drug using population. It recommended health service development to target the needs of the homeless population (O'Carroll & O'Reilly, 2008).

Since the 2005 study, a number of studies have confirmed that the burden of disease in homelessness is disproportionately greater than that of the general population with some suggestion that health care access had improved. However since 2005, there were no comparable studies to the original 1997 survey.

Given the service development in the sector, the time lapse since the last study and the development of the economic crisis in the interim, the Partnership for Health Equity decided to repeat the health survey in Dublin and to conduct a baseline survey in Limerick in the interest of planning and service development.

## Study objectives

The aim of the study was to assess the health status of the homeless population of Dublin and Limerick cities and their access to and utilisation of health services, thus establishing change over time in Dublin and a baseline in Limerick against which to measure service change and development going forward.

### The objectives were as follows:

1. Describe demographics and reasons for becoming homeless
2. Describe factors associated with homelessness
3. Describe the behaviour-related health risk factors
4. Determine the health status and use of health services
5. Establish the change in the above in Dublin since the 2005 and 1997 studies.

## 2. Background Literature

### **The number of homeless people in Ireland fell during the economic boom but rose in the subsequent recession.**

Though comparing estimates of the number of homeless is problematic due to differing methodologies, the U-shaped distribution over time is generally accepted (2,900 in 1999 [Williams & O'Connor, 1999], 2,920 in 2002 [Williams & Corby, 2002], 2,280 in 2005 [Homeless Agency, 2005], 2,366 in 2008 [Homeless Agency, 2008; DOHC, 2006] and 3,808 in 2011 [CSO, 2012]). The 2011 census was the first to identify and enumerate homeless people. The majority (2,375) were located in Dublin (CSO, 2012).

Homeless people have much worse physical health than the general population. Although the same range of health conditions as the general population are experienced, they are experienced with greater frequency and severity and are developed at a younger age (Bagget et al., 2010; Smith et al., 2001; Holohan, 1997; Herndon et al., 2003). Furthermore, diseases that are rare in the general population such as HIV, Hepatitis and TB are common amongst homeless people (O'Carroll & O'Reilly, 2008; Hwang et al., 2009; Beijer et al., 2011). Not surprisingly, homeless people die at a younger age than housed people (Hwang et al., 2009; Beijer et al., 2011). Ultimately, they are caught in a vicious circle where homelessness causes poor health, while poor health causes homelessness. This vicious circle makes it more difficult to escape homelessness and makes it more likely that they will die homeless.

As with physical health, homeless people are much more likely than the general population to suffer mental health conditions such as schizophrenia, depression, anxiety and post-traumatic stress disorder (Smith et al., 2001; Condon et al., 2001; Sibthorpe et al., 1995; Eynan et al.,

2002). Studies have shown that between a third and a half of homeless people have attempted suicide (Eynan et al., 2002; Gorde et al., 2004). Many of the factors causing this poor mental health such as histories of dysfunctional families, sexual and/or physical abuse, institutionalisation in care as children and relationship breakdown, precede homelessness (Gorde et al., 2004; Bernstein & Foster, 2008). The harshness of the homeless existence also causes or exacerbates poor mental health (Caton et al., 2007).

Homelessness is classically associated with both alcohol and drug addiction (O'Toole et al., 2004; Van Leeuwen et al., 2004). Internationally, alcohol has been replaced by drugs as the main addiction for homeless people (Smith et al., 2001; Condon et al., 2001). International studies estimate that between half and over three quarters of homeless people misuse drugs with injecting drug use being very common, while Irish studies estimated one third of homeless people were actively using drugs. This risk behaviour further contributes to the spread of HIV and Hepatitis and other blood borne diseases amongst homeless people (Abdul-Hamid & Cooney, 1996; Gelberg & Leake, 1993). Homeless drinkers too have very poor health with many having alcohol related liver and neurological damage (Grinman et al., 2010; Nyamathi et al., 2010).

People who have both a substance misuse and mental health problem have particular difficulties exiting homelessness and taking care of their physical and mental health. This co-occurrence of mental health and addiction problems has been termed 'dual diagnosis' and between

2-24% of the homeless population have been found to have this diagnosis (Bhareel et al., 2013; Wright et al., 2003).

Despite their poor health, homeless people have been known to make less use of health services. They tend to delay going to a health service and so when they eventually do present, it is generally late on in the course of their illness when the condition is severe and often overwhelming and so requiring hospitalisation. Even when they do attend they often leave before they have been seen or, if admitted to hospital, discharge themselves prior to being fully treated (Wen et al., 2007; Zlotnick & Zerger, 2009; Kushel et al., 2001). Homeless people are also less likely to keep hospital outpatient appointments (Haddad et al., 2005; Wen, Hudak, & Hwang, 2007).

Internationally and in Ireland, homeless people commonly use the hospital Emergency Department with international attendance rates 2½ to 5 times that of the general population and Irish studies showing double the attendance rate (Beijer et al., 2011; Wen, Hudak, & Hwang, 2007; Chambers et al., 2013). Homeless people are more likely than the general population to be admitted to hospital with admission rates to general hospitals 2½ to 7 times that of the general population and to psychiatric hospitals 5 to 100 times higher (Wen et al., 2007; Fisher & Collins, 1993). Due to the fact they are usually sicker than the non-homeless person they spend more days in hospital (Hwang et al., 2011).

This pattern of late presentations, high usage of Emergency Departments and increased and prolonged inpatient admissions means that homeless people account for significant costs to the health services (Fuehrlein et al., 2014).

In contrast, homeless people are known to be poor at attending primary care and preventative services internationally and in Ireland (Fisher & Collins, 1993; Wright, 2002). In the UK, homeless people were 40 times less likely to be registered with and 3 times less likely to have had contact with a GP. Irish studies found that many homeless people did not have a medical card though it would be fair to presume all would be entitled to one. Similarly, homeless people had lower attendance rates than would have been expected taking into account both

their ill health profile and comparison with attendance rates of the domiciled population (Feeney et al., 2000; Holohan, 1997; Haddad et al., 2011).

There have been many reasons identified for poor use of such services including difficulties with complex administrative forms; difficulties making and keeping appointments due to the chaos of homelessness; being too busy to attend due to other priorities such as looking for food, shelter, money and if they are addicted, alcohol or drugs. They also face significant discrimination from primary care practitioners and their staff (Gelberg et al., 1997; Crisis, 2002).

In summary, homeless people are sicker and have more mental health problems than the general population. Despite this, they seem to use health services in a manner that does not address their health needs. They make less use of primary care, preventative and outpatient services. They then present late in their illness to hospital Emergency Departments and are more likely to be admitted and are less likely to stay in hospital for full treatment. All of this illustrates Tudor Hart's Inverse Care Law i.e. those in most need of services are least likely to receive them. Improving the health status and service usage of homeless people may lead to a reduction in their excessive suffering and a reduction in costs to the health services. It may also help them to exit homelessness. This study aimed therefore to assess the health status of the homeless population of Dublin and Limerick cities and their access to and utilisation of health services. It sought to establish change over time in Dublin and a baseline in Limerick against which to measure service change and development going forward.



# 3. Study Design and Methods

**The study design was a cross-sectional survey of homeless people in Dublin and Limerick cities during the second two weeks of September 2013.**

We used a European descriptive typology (ETHOS) that has been developed as a research tool to provide a way of structuring research on homelessness so that valid comparisons can be made across European countries (The Homeless Agency, 2009). Within this typology, there are four conceptual categories of homeless persons, namely roofless, homeless, insecure and inadequate. This study targeted the two most 'in need' of the ETHOS operational conceptual categories; a) 'roofless' i.e. people sleeping rough or people in emergency accommodation and b) homeless people in designated accommodation for homeless, which is of a temporary nature (The Homeless Agency, 2009). Together with the relevant authorities in Dublin and Limerick a list of all the relevant accommodations within Dublin and Limerick cities was compiled. This included all Emergency Accommodations (EAs) identified by the local authority in Limerick. It included all Supported Temporary Accommodations (STAs) as well as Private Emergency Accommodations (PEAs) in Dublin City identified through the Dublin Region Homeless Executive (DRHE). The study did not include accommodations outside the city centre except for one accommodation designated for foreign nationals in Tallaght. This was included to increase representation of this category as accommodations for foreign nationals were under-represented in the city centre.

The study inclusion criteria was homeless persons 18 years or over, who, at the time of the study, were resident in Emergency Accommodation (EA), Supported Temporary Accommodation (STA), Private Emergency Accommodation (PEA) or sleeping rough, in Dublin and Limerick city.

The study received ethical approval from the Education and Health Sciences Faculty Research Ethics Committee in the University of Limerick.

## 3.1 Sample Selection

The sampling strategy reflects the strategy used in the previous studies (Holohan, 1997; O'Carroll & O'Reilly, 2008). The sample therefore reflects the homeless population in a particular type of accommodation (Supported Temporary Accommodation, and Private Emergency Accommodation) in the city rather than the full homeless population, much of which is accommodated outside the city centre and in different types of accommodation. The total number of people who meet the definition of homeless is derived from the numbers who stayed at these accommodations the night prior to the survey. The total targeted was therefore 910 staying in these accommodations. One research assistant also accompanied the Dublin Simon Community Rough Sleeper Team on two nights to interview a small sample of rough sleepers (23). The estimate of rough sleepers made by the team was circa 70 on the nights in question. The official count of rough sleepers on one night in March 2013 for the Dublin region was 94 and 139 in November 2013 (DRHE, 2014).

### Dublin:

The 2011 Census estimated 2,375 homeless people in the Dublin area (CSO, 2012). The number of people (staying in STAs or PEAs) recorded on the Pathway Accommodation and Support System (PASS)<sup>2</sup> in the Dublin region (city and county), on the last night of September, 2013 was 1,431.

The sampling methodology used for this study was based on that used in the 1997 study which targeted those in purpose-run hostels, bed and breakfasts and sheltered housing in Dublin City (Holohan, 1997). In 2005, the same methodology was used; however, due to resource limitations, only north Dublin city was targeted. In 2013, all accommodations meeting the specified criteria in both north and south Dublin city were included.

### Limerick

The 2011 Census identified 273 homeless people in the Mid-West but figures for Limerick were not given specifically. Conversations with representatives of Limerick City Council (LCC) indicated that six accommodations met with the study criteria. These were classified

as Emergency Accommodation. All these accommodations were included in the study. Rough sleeping was reported to be rare and was not included in the study.

In summary, there was an overall response rate of 64% of those staying in the included accommodations (63 in Limerick and 515 in Dublin). A further 23 rough sleepers were included in Dublin giving a total of 538 interviewed in Dublin and 63 interviewed in Limerick. Table 1 summarises the type and number of accommodations involved in the study, their location, total number of residents on the night before the survey and response rate. The response rate excludes rough sleepers.

**Table 1: Accommodation type, location and response rate**

Accommodation type	Numbers of accommodations	City	Residents present in accommodation night prior to survey	Number participated in survey	Response rate (%)
Supported Temporary Accommodation	31	Dublin	485	329	68%
Private Emergency Accommodation	13	Dublin	291	186	64%
Emergency Accommodation	6	Limerick	134	63	47%
<b>Total in homeless accommodation</b>			<b>910</b>	<b>578</b>	<b>64%</b>
<b>Rough Sleepers</b>				<b>23</b>	
<b>Total Interviewed</b>				<b>601</b>	

The total sample size for Dublin is 538 (including rough sleepers) and the total sample size from Limerick is 63.

<sup>2</sup> The Dublin Region Homeless Executive (DRHE) has established the Pathway Accommodation and Support System (PASS), which is an online system that generates vital information in terms of managing access to accommodation. <http://www.homelessdublin.ie/pass>

### 3.2 Questionnaire

The interviewer-administered questionnaire was anonymous and this was stressed to all potential interviewees. The questionnaire used in the 1997 survey was adapted in the 2005 survey and was further adapted in 2013 to capture information that was relevant to today's population and for service planning e.g. questions about suicide were introduced for the 2013 survey.

The questionnaire had four distinct sections: demographics and homelessness, addiction, health status and use of health services. It was mainly comprised of closed-ended questions but also had a small number of open-ended questions. A final question asked respondents for recommendations on how services could be improved.

#### Interviews

Once the questionnaire had been piloted with homeless people by the Principal Investigator, three teams of four (one team leader and three researchers) in Dublin and one team of two (two interviewers) in Limerick conducted the survey over a two week period. All teams were trained in questionnaire administration as well as made aware of safety and supervision protocols. The researchers received written consent from the participants prior to the interview. The interviewer-administered questionnaire took approximately 20 minutes to complete. Each participant was given an €8 general store voucher in appreciation of their participation.

### 3.3 Analysis

The analysis focuses on descriptive statistics which are provided for the Dublin and Limerick samples separately and comparison of these with the 1997 and 2005 for the Dublin sample. Trends over time (1997, 2005, and 2013) are displayed graphically. The data sets from the previous surveys were available to the Principal Investigator. Comparisons are made where the question was asked in the same way or of the same group or subgroup. Given that the results are from samples, there is an associated margin of error in the estimates. This is likely to be small given the large sample sizes and the proportion of the population being sampled.

Counts and percentages are given for the categorical data in the study. The strength of the association between categorical variables was tested using the Chi-square test and a 5% level of significance. No adjustment was made for multiple testing. The results of formal hypothesis tests (largely using Chi-square tests) are not reported here as is appropriate for a lay audience however these can be made available on request. Response rates for individual questions were high and the number of respondents is reported in each summary table. Bivariate analysis examined what factors may influence or be associated with aspects of addiction, health and health service usage.

### 3.4 Presentation of Results

Results are presented in four sections namely i) Demographics ; ii) Addiction; iii) Health; iv) Access to and use of health services. Each section summarises results on the particular theme and places them in the context of other research and findings for the general population where available. Each section also presents the important findings as highlights at the start of the section. There is then a brief synthesis and discussion of the four sections prior to conclusions and recommendations.



Photo Credit: Hugh McElveen

# 4. Demographics

## Highlights

Respondents were asked about general characteristics including ethnicity, employment and social welfare payments received. They were also asked how long they were homeless and the main reasons for their homelessness.

- Two out of three homeless people in the sample were male. Most of the sample was under 45 years of age.
- The sample was mainly White Irish and Roman Catholic, with greater diversity in Dublin.
- Although the vast majority were single, more than half were also parents. However, relatively few had their children living with them.
- The vast majority were unemployed and were in receipt of some form of social welfare payment. In Dublin, the most common payment was Job Seekers Allowance while in Limerick it was Disability Allowance.
- More than two thirds in Dublin were long-term homeless. In Limerick, less than half were.
- The most common reasons for homelessness were drug or alcohol addiction or family problems.
- Almost one fifth had been in care as children.

### 4.1 General Demographics

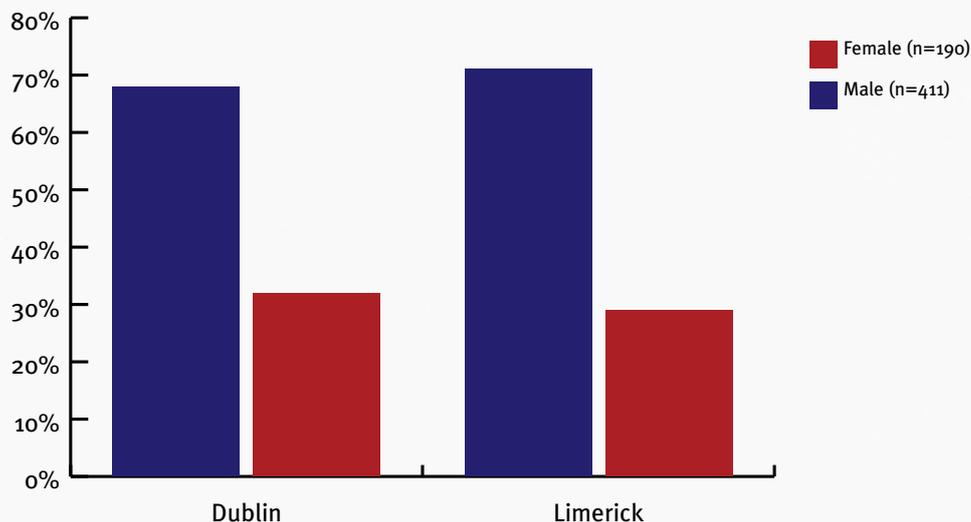
This section describes the study sample by gender, age, ethnicity, religion, marital and parental status.

#### 4.1.1 Gender

Men accounted for more than two thirds of the sample in both Dublin (68%) and Limerick (71%). The percentage

of women who were homeless (32%) represents a significant increase compared to 1997, where just 15% of all homeless people in Dublin were female (Holohan, 1997) but is slightly less than in the 2005 study when 39% of the homeless sample in Dublin were female (O’Carroll & O’Reilly, 2008).

**Figure 1: Gender of participants**



#### 4.1.2 Age group

The homeless people in this study were predominantly young, with almost half of the sample under the age of 35 and more than three quarters of the sample under the age of 45. This is a younger population compared to the general population in which 44% are between the ages of 15 and 45 (CSO, 2012). Furthermore, fewer homeless people (6%) were aged over 55 compared to the general

population (22%) (CSO, 2012). The results are similar to the CSO Special Report on Homelessness (CSO, Special Report, 2012) and in keeping with the 2005 study which found 81% of Dublin homeless were under 45 years old (O’Carroll and O’Reilly, 2008). Limerick had a higher proportion of people over 45 years of age (31%) compared to Dublin (21%).

**Figure 2: Age group**



#### 4.1.3 Ethnic or cultural background

The general Irish population is largely ethnically homogeneous with 86% in 2011 identifying as White Irish (CSO, 2011). The homeless sample largely reflects this with previous studies also finding that White Irish was by far the most common ethnicity (Holohan, 1997; O’Carroll and O’Reilly, 2008). The Limerick sample was ethnically homogeneous with almost all participants describing themselves as Irish. A very small minority (n=4, 7%) described themselves as having ‘any other white background’. The sample in Dublin was more diverse. Although Irish ethnicity still predominated (83%), ethnicities including any other white background, Irish Traveller, African, mixed ethnic background and other Asian background were represented as minorities. The proportion describing themselves as Irish Traveller (4%) was far higher than in the general population (0.6%) (CSO, 2012). The CSO Special Report on Homelessness (CSO, 2012) similarly records a greater diversity in ethnicity in Dublin, where 80% of the population identified as Irish.

#### 4.1.4 Religion

Similar to the ethnic background of the population, the Limerick sample presented more homogeneity in religious affiliations with 94% identifying themselves as Roman Catholic. This figure is higher than the general population of which 84% identified as Roman Catholic (CSO, 2012). Again, Dublin demonstrates greater diversity in religious background. While the vast majority (80%) identified as Roman Catholic, 11% described themselves as Christian or other. The profile among the Dublin homeless reflects that of the general population of Dublin in which approximately 78% identified as Roman Catholic and 5% as other (CSO, 2012). The percentage of those with no religion was more than five times higher in Dublin than in Limerick. Data from the CSO similarly show a much higher percentage of those with no religion in Dublin (CSO, 2012) compared to other counties.

**Table 2: Ethnic or cultural background**

		Dublin	Limerick	Total	
		n	514	62	576
Ethnic or Cultural Background	White Irish	83.1%	93.5%	84.2%	
	Irish Traveller	4.3%	0.0%	3.8%	
	Any other white background	8.0%	6.5%	7.8%	
	African	3.3%	0.0%	3.0%	
	Any other Asian background	.2%	0.0%	.2%	
	Other including mixed background	1.2%	0.0%	1.0%	

**Table 3: Religion**

		Dublin	Limerick	Total	
		n	514	63	577
Religion	Roman Catholic	80.2%	93.7%	81.6%	
	Christian	4.9%	0.0%	4.3%	
	None	8.6%	1.6%	7.8%	
	Other	6.4%	4.8%	6.2%	

#### 4.1.5 Marital status

Overall, nearly three quarters of the sample were single. This is a far higher percentage of single people than in the general adult population where single people account for 42% (CSO, 2012) and is also higher than was found in 1997, where 66% of the homeless population were described as single (Holohan, 1997), and in 2005 where 54% identified as single (O’Carroll and O’Reilly, 2008). Data from this current study found that 79% of the Limerick sample was single with most of the remaining individuals separated or, a small minority, widowed or cohabitating. In Dublin, the majority (72%) were single and 10% were separated. However, larger proportions of the sample were cohabitating, divorced or married compared to the Limerick sample. As in Limerick, a very small minority were widowed.

#### 4.1.6 Parents and children

The majority (64%) of the homeless who took part in the study were parents. However, only a minority of these had their children living with them, resulting in 63 children also homeless. While the proportion of the homeless people who were parents is roughly similar to 2005, the proportion that had children living with them was much lower (O’Carroll and O’Reilly, 2008). Those living in Private Emergency Accommodation (PEA) were far more likely to have children living with them (15%) compared with those who were staying in Supported Temporary Accommodation (STA) (2%). The under representation of PEA accommodation in our sample compared to the full homeless population in the Dublin Region<sup>3</sup> suggests that the proportion of parents with children living in homelessness in the full homeless population is higher than we found.

**Table 4: Marital status**

		Dublin	Limerick	Total
n		538	63	601
Marital Status	Married	2.8%	0.0%	2.5%
	Single	71.6%	77.8%	72.2%
	Separated	9.7%	19.0%	10.6%
	Divorced	3.9%	0.0%	3.5%
	Widowed	1.5%	1.6%	1.5%
	Co-habiting	10.6%	1.6%	9.7%

**Table 5: Parents and children**

		Dublin	Limerick	Total
n		538	63	601
Homeless persons who were parents		64.9%	60.3%	64.4%
Number of parents		336	38	374
Of parents, those with children living with them		8.9%	15.8%	9.6%
Number of children living in homelessness		49	14	63

<sup>3</sup> Our sample was compared to Pathway Accommodation Support System (PASS) data for 30th September 2013 (made available by the Dublin Region Homeless Executive (DRHE)). While there were similar numbers accommodated in STA and PEA accommodation in the Dublin region according to the PASS system our sample includes almost twice as many accommodated in STA compared to PEA accommodation.

## 4.2 Employment and Social Welfare

Homelessness and unemployment are strongly associated. This study found approximately 96% of the sample was unemployed. However, it is notable that homelessness is not synonymous with unemployment, as 5% in both Dublin and Limerick were working and homeless. The CSO Special Report on Homelessness (2012) similarly found that 8% of the homeless individuals in their study were currently in work.

Reflecting the numbers of homeless people who were not currently working, approximately 95% of the sample was in receipt of a social welfare payment. Social welfare payments received by the sample represented a number of different types of support, including job seekers benefit/allowance, disability payment, other illness related benefit, supplementary welfare allowance, lone parent payment, back to education allowance, retirement pension and others. While the job seekers payment was received by the largest percentage of the Dublin sample, with almost half receiving this payment, over one third were receiving

disability payment. Of note, in Limerick, over half of the sample received the disability payment and a further 5% received another illness related benefit. High rates of disability payment are not unexpected given the high rate of disability found among the homeless population in Ireland in other studies (CSO, 2012), but the regional differences in receipt of this payment may suggest the influence of other factors, such as differential access to support services for the disabled or to economic supports. The regional difference in the receipt of disability payment is statistically significant, indicating that differences in the rates remain after accounting for different sample sizes.

Other differences include the slightly higher proportion of those receiving Lone Parent Benefit in Limerick and while some of the Dublin sample received Supplementary Welfare Allowance, no one in the Limerick sample received this payment. In general, the Dublin sample accessed a wider range of payments than those in the Limerick sample.

**Table 6: Employment and social welfare**

		Dublin	Limerick	Total
Employment	n	538	63	601
	Working	5.2%	4.8%	5.2%
	Not working	94.8%	95.2%	94.8%
Social Welfare	n	537	63	600
	In receipt of social welfare	95.9%	93.7%	95.7%
	Not in receipt of social welfare	4.1%	6.3%	4.3%
Type of Payment	n	513	57	570
	Job seekers	42.7%	35.1%	41.9%
	Disability	34.9%	50.9%	36.5%
	Other illness related benefit	1.8%	5.3%	2.1%
	Supplementary welfare allowance	11.1%	0.0%	10.0%
	Lone parent	2.7%	5.3%	3.0%
	Community employment payment	2.7%	0.0%	2.5%
	Homeless payment	1.6%	0.0%	1.4%
	Back to education	1.0%	0.0%	.9%
	Retirement pension	.6%	0.0%	.5%
	Other	1.0%	3.5%	1.2%

### 4.3 Experience of Homelessness

Though all respondents were in homeless accommodation or sleeping rough not everyone considered themselves as homeless. In Dublin 94% and in Limerick 92% said they considered themselves as homeless suggesting varying understandings of homelessness (e.g. some may have considered only sleeping rough as homeless).

### 4.4 Length of Time Spent Homeless

In Dublin, more than two thirds of the sample reported being homeless for more than 6 months and thus are categorised as long-term homeless. In fact, more than half of the sample had been homeless for more than a year and 41% had been homeless for between 1 and 12 months. In contrast, homelessness in Limerick appears to be more often short-term with less than half the sample identified as long-term homeless. Almost one fifth of those in the Limerick sample had been homeless for less than one month and half for 1 to 12 months. The proportion of people who were homeless for more than a year (50%) has reduced from 2005, where 66% of the homeless sample were homeless for more than a year (O'Car-

roll and O'Reilly, 2008), and is slightly higher than in 1997 (45%) (Holohan, 1997).

In both Dublin and Limerick, the majority of the sample had experienced previous episodes of homelessness suggesting that an experience of homelessness is a predictor for future episodes of homelessness.

### 4.5 Accommodation Type

In Limerick, the entire sample were staying in what is described as Emergency Accommodation. This directly reflects the sampling strategy. In contrast, in the Dublin sample the category of accommodation described as Supported Temporary Accommodation (STA) was used by a little more than half of the sample, and a third used Private Emergency Accommodation (PEA). Private NGOs also provided accommodation to a small minority of the sample and another form of private emergency accommodation was used by homeless foreign nationals. A small minority (4%) of the sample from Dublin did not access any form of accommodation but were sleeping rough.

**Table 7: Duration of homelessness and previously homeless**

		Dublin	Limerick	Total	
		n	512	59	571
Homeless > 6months		68.4%	42.4%	65.7%	
Duration of homelessness	< 1 month	7.0%	18.6%	8.2%	
	1-12 months	40.8%	49.2%	41.7%	
	> 1 year	52.1%	32.2%	50.1%	
		n	501	62	563
Previously homeless		63.3%	56.5%	62.5%	

**Table 8: Accommodation type**

	Dublin	Limerick	Total
n	538	63	601
Private Emergency Accommodation	32.2%	0.0%	28.8%
Supported Temporary Accommodation	53.2%	0.0%	47.6%
Rough Sleeping	4.3%	0.0%	3.8%
Private NGOs	5.0%	0.0%	4.5%
Emergency Accommodation (Limerick)	0.0%	100.0%	10.5%
Accommodation for Foreign Nationals	5.4%	0.0%	4.8%

#### 4.6 Reasons for Homelessness

The sample was asked what they perceived as the main reason for their homelessness. 599 respondents gave at least one main reason for their homelessness and 197 gave two reasons for their homelessness. Both reasons were taken into account to determine the proportions giving the most frequently cited reasons for homelessness (Table 9). Family problems were given as a reason for homelessness by 36% of the sample. Grouping family or relationship problems, including domestic violence, accounted for reasons cited by almost half the sample. When reasons were grouped together almost three quarters of the sample identified either drug or alcohol addiction or family problems (including relationship problems and domestic violence) as the main reasons for their homelessness. Addiction alone (drug or alcohol) was given as a main cause of homelessness by nearly 40% of the sample. Of note, almost twice as many respondents from Limerick identified the cause of their homelessness as alcohol alone compared to the Dublin sample.

Family problems and addiction were the main reasons for homelessness given by the majority of participants across the three studies (1997, 2005, 2013). Other reasons identified by respondents as the reason for homelessness included crime, mental health problems, financial problems or eviction.

Perhaps surprisingly, given the occurrence of the economic recession since the last survey, there was a slightly lower proportion (10%) giving financial reasons as the main reason in 2013 than in 2005 (13%), and much lower than that reported in 1997 (20%). There was also a lower

proportion of those citing evictions in 2013 (3%) compared with 7% in 2005 and 1997. This may be the result of protective policies aimed at preventing homelessness as a result of inability to pay rent or evictions from council accommodation, absorbing or delaying the effects of the financial crisis. However, the reasons for homelessness are complex and multi-factorial and are not adequately captured though citing one or two main reasons as asked in this survey. Financial crisis can lead to family problems and increase family breakdown and addiction. In our sample, the low representation of Private Emergency Accommodation (PEA) in which families are more likely to be housed, may also mean that those becoming homeless as a result of the recession may be less likely to be seen (discussed below). However, it does appear that within our sample the reason for homelessness seems to differ depending on duration of homelessness. Those homeless for less than 6 months were more likely to give financial problems as the reason for homelessness (18% vs 8%) and those homeless for more than 6 months were more likely to give drug or alcohol addiction as the main reason for homelessness (43% vs 28%). Those homeless due to financial problems transition through homelessness quicker and are therefore less likely to be among the long term homeless, unlike those with an addiction.

Acknowledging the inadequacy of asking for a 'main reason' for homelessness, this attempt to gain an understanding of self-perceived reasons for homelessness sees the importance of substance abuse and family related problems which account for three quarters of the reasons given by respondents in 2013. While this question was asked differently across the three surveys, the findings show that these determinants accounted for an increas-

**Table 9: Main Reason for homelessness**

	Dublin	Limerick	Total
n	536	63	599
Family or relationship problems or domestic violence	48.1%	55.6%	48.9%
Crime	5.0%	6.3%	5.2%
Mental health problems	4.7%	7.9%	5.0%
In care as a child	2.6%	0.0%	2.3%
Alcohol	12.7%	22.2%	13.7%
Financial or eviction	15.3%	11.1%	14.9%
Other	12.5%	7.9%	12.0%
Drugs	27.4%	22.2%	26.9%
Drugs or alcohol	37.9%	39.7%	38.1%
Drug or alcohol or family problems	73.3%	77.8%	73.8%

ing amount of the reasons given in all surveys (69% in 2005 and 56% in 1997). The interconnection between substance abuse and family problems cannot be disentangled; drug problems may have caused the family problem in the first place or indeed vice versa. ‘Financial reasons’ was more frequently reported in 1997, with 20% giving it as a reason for their being homeless. It was notable that almost one fifth of the sample (19% in Dublin and 18% in Limerick) had been in care as a child, yet just 3% of the Dublin sample and none of the Limerick sample identified this experience as a main reason for their homelessness. Given that, currently, the rate of children in some form of state care is 5.4 per 1000 population (Tusla, 2014), there is a much higher proportion of homeless adults who had been in care as children than would be found in the general population. This suggests that this factor is associated with homelessness as reflected in the literature (Ringwalt et al., 1998).

#### 4.7 Changes Over Time

It is important to note that the composition and characteristics of the homeless population in this study is influenced by our sampling strategy which includes specific types of accommodation in specific locations and therefore describes a sample rather than the full homeless population. Figure 3 captures the changes in sample characteristics over time. While the methodology mirrored

that used in the previous studies it must be remembered that the structure and profile of the study samples is influenced by the availability of differing types of homeless accommodation in different locations. An example of this is the higher proportion of foreign nationals in 1997. This can be explained by the fact that refugees and asylum seekers at that time were accommodated in city centre B&B’s, which were part of designated homeless accommodation. With the establishment of direct provision centres and latterly the introduction of the Habitual Residential Condition, we see a reduction in the proportion of foreign nationals among the sample, thus demonstrating how structural influences define sample characteristics. The numbers, locations and types of homeless accommodations in Dublin city has changed over time so that the three studies will reflect sample characteristics determined by how services are configured and where they are located.

Among these sizable samples, we find increasing representation of single people and men, suggesting lower proportions of families among our sample. The age profile is similar to the 2005 survey and younger than the 1997 survey. Notably, people who were in state care as children have consistently been over represented among the homeless samples.

The proportion of parents accompanied by children in 2005 was higher than found in our sample (O’Carroll & O’Reilly, 2008). As mentioned previously, the effect of the sampling strategy and reconfiguration of homeless accommodations has meant that those accommodations more likely to accommodate families were less represented in our sample. The under representation of PEA accommodation which houses more families, in our sample, suggests the true proportion of parents with children homeless at the time of our study was likely to be higher in the Dublin region than we found in our sample, however it is unlikely to have been as high as in 2005. This is corroborated by the homeless census that found 10% of the homeless population were parents accompanied by children (CSO, 2012). It is also noted that there was an increase in families entering homelessness soon after our study in the last quarter in 2013. These new homeless were accommodated in hotels as accommodation designated for families reached capacity<sup>4</sup>.

#### 4.8 Summary

The homeless population in this study were predominantly under 45 years, male, Irish, and Roman Catholic. They were mainly single though most also had children who were not living with them. Very few were engaged in paid work and the vast majority subsisted on social welfare payments.

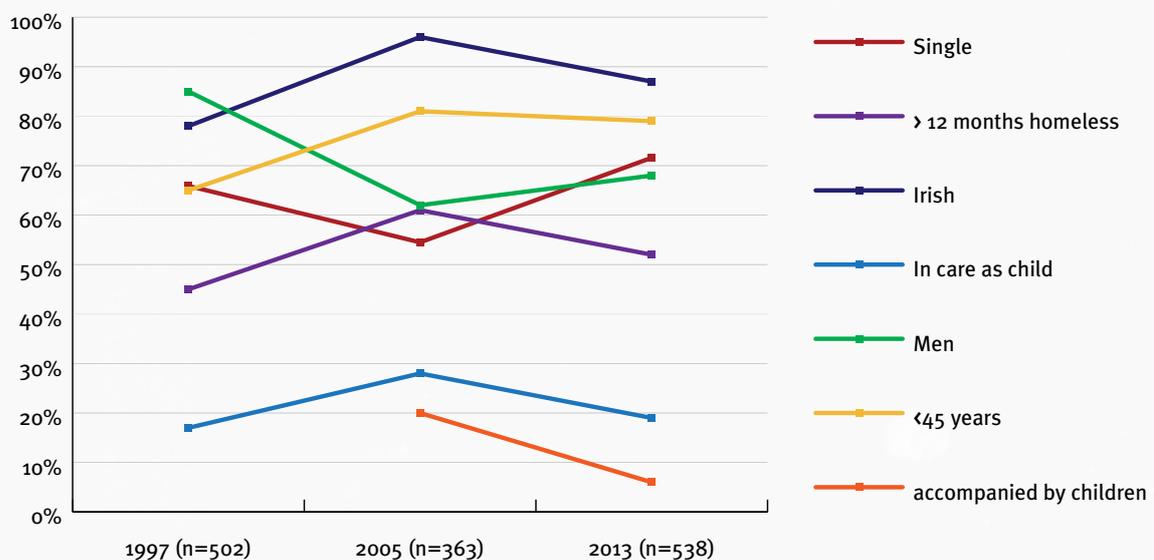
While this is the general profile of the homeless individuals who participated in this study, it is important to

recognise that the sample was not fully homogeneous: one third of the sample were female, a variety of ethnicities and religions were present, some individuals were in employment and some had children who lived with them, resulting in 63 children identified as homeless in this study. Recognising the diversity amongst the homeless population is as essential as understanding the common features of this population group. The sample was younger than the general housed population and predominantly male and single (CSO, 2012). The sample was similar to the general housed population in terms of ethnicity and religion (CSO, 2012).

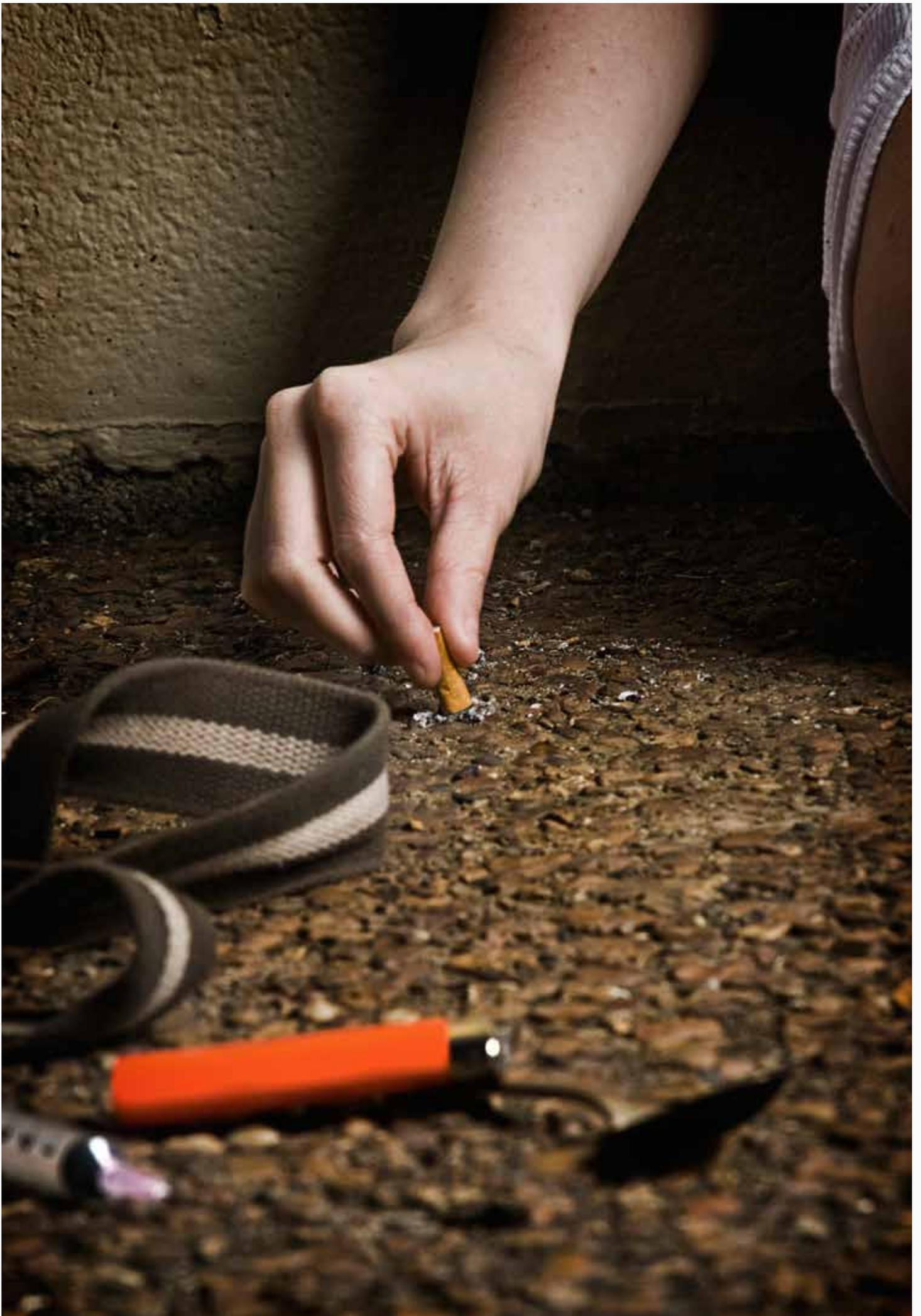
Family problems, drugs and alcohol addiction featured heavily as reasons for homelessness, as identified by the study participants themselves. Homelessness was often long-term: 68% of the Dublin sample was homeless for more than 6 months, as was 42% of the Limerick sample. Furthermore, the majority in Dublin and Limerick stated that they had been homeless on a previous occasion.

Although it was recognised by a small minority as a reason for their homelessness, there was a disproportionate number of the sample who had been in care as a child, potentially indicating the importance of social supports in preventing vulnerability to homelessness.

**Figure 3: Changes in characteristics over time**



<sup>4</sup> Personal Communications Dr B O’Donoghue Hynes, Head of Research, Dublin Region Homeless Executive



# 5. Addiction

## Highlights

Respondents were asked about smoking, drinking and illicit drug use. Those who said they had used illicit drugs in the past were asked an additional set of questions about type of drugs used. A subset of people who believed that they had a drug or alcohol problem were asked about their main addiction and the services they used.

- Almost universal smoking
- Dramatic rise in dangerous drinking among homeless women
- Illicit drug use still highly prevalent with rise in illicit benzodiazepine use
- Poly drug use is the norm with high use of prescribed sedatives and minor tranquilizers
- Widespread coverage of methadone treatment with low numbers waiting
- Little change in addiction service utilisation with the highest numbers waiting for inpatient detox
- Reduced self-report of heroin as main drug of addiction
- More drinking among Limerick homeless and drug use among Dublin homeless

## 5.1 Smoking

The vast majority of the sample (91%) smoked tobacco. Most smokers smoked rolled cigarettes or smoked a mixture of branded and rolled cigarettes. Most smokers smoked over 10 cigarettes per day. There was a higher proportion of heavy smokers in the Limerick sample (defined as greater than 20 cigarettes per day) compared to the Dublin sample.

The prevalence of smoking among the homeless sample was more than three times higher than the general population (27%) (Brugha et al., 2009). While the SLAN 2007 study found higher rates among men and the younger population, all subgroups had equally high rates of smoking in the homeless survey.

**Table 10: Smoking**

		Dublin	Limerick	Total
	n	532	62	594
Current smoker		90.4%	93.5%	90.7%
Type of tobacco	n	460	58	518
	Branded & rolled	22.4%	12.1%	21.2%
	Branded	22.2%	24.1%	22.4%
	Rolled	54.3%	63.8%	55.4%
	Other	1.1%	0.0%	1.0%
No. of cigarettes	n	478	58	536
	< 1 per day	1.0%	5.2%	1.5%
	1-10 per day	35.6%	19.0%	33.8%
	11-20 per day	41.6%	44.8%	42.0%
	21-30 per day	14.4%	20.7%	15.1%
	> 30 per day	7.3%	10.3%	7.6%

## 5.2 Alcohol Consumption

Abstinence (not having consumed alcohol in the past year) was twice as prevalent in Dublin compared to Limerick (Table 11). This may be related to the higher prevalence of opiate use in Dublin. Alcohol abstinence was more commonly reported among heroin users than those reporting never using heroin (21% vs 14%). However, daily alcohol consumption among drinkers was more

prevalent in Dublin than in Limerick, while drinking only 2 or 3 times a week was more prevalent in Limerick. Those who did drink tended to drink 5 or more drinks on a typical drinking occasion, with 68% of the sample drinking 5 or more drinks when they drank alcohol. Approximately 41% of the sample drank more than current recommended limits.

**Table 11: Alcohol consumption**

		Dublin	Limerick	Total
	n	531	59	590
Non-drinkers (in last 12 months)		19%	10%	18%
	n	523	59	582
Frequency of alcohol use	Daily	22.8%	13.6%	21.8%
	4/5 times a week	4.0%	6.8%	4.3%
	2/3 times a week	12.6%	30.5%	14.4%
	Once a week	9.2%	10.2%	9.3%
	2-3 times a month	4.0%	0.0%	3.6%
	Once a month	7.8%	16.9%	8.8%
	< Once a month	19.9%	11.9%	19.1%
	Not at all	19.7%	10.2%	18.7%
	n	504	55	559
5+ drink on typical occasion		67.9%	70.9%	68.2%
	n	501	56	557
Above weekly recommended limits	17+ standard drinks for men / 11+ standard drinks for women	40.1%	44.6%	40.6%

### 5.3 Comparison of Drinking Behaviour with SLAN 2007

The table below shows similar proportions of homeless and housed were abstainers. There was a higher proportion of abstinence in the younger homeless sample (age 18-29) compared to the young housed population and a very low rate of abstinence in the older homeless sample (age 65+) compared to the housed population. It must be noted, however, that the homeless sample only contained 6 respondents aged over 65. Younger homeless people (particularly in Dublin) tended to be drug users rather than drinkers. More men than women drank at least twice a week in both the homeless and housed populations and in similar proportions. When it came to drinking more than 5 drinks on one occasion more of the homeless population compared to the housed population reported this. While men were twice as likely to engage in this kind of drinking in the housed population, women in the homeless population were closer to their male counterparts in this style of drinking.

In 1997, 29% of all respondents were found to drink beyond recommended limits, according to the Department

of Health guidelines at the time (21 units per week for males or 14 units per week for females). This proportion was similar in 2005 with 28% of the sample drinking beyond these limits (37% of men and 12% of women). In 2013, we found a significant increase in heavy drinking - 39% of the sample reported drinking above recommended limits (41% of men and 36% of women). The trebling of the rate among women since 2005 is noteworthy. The SLAN 2007 survey showed that 11% of men and 5% of women in the general population drank above these limits. On the basis of new Department of Health recommended limits (17 standard drinks for men and 11 for women), 41% of the homeless people surveyed reported drinking above limits.

### 5.4 Illicit Drug Use

464 (78%) respondents said they were using illicit drugs currently or had a history of use. Over half (55%) of the sample reported current (within the last 3 months) drug use.

**Table 12: Alcohol consumption comparison with housed population**

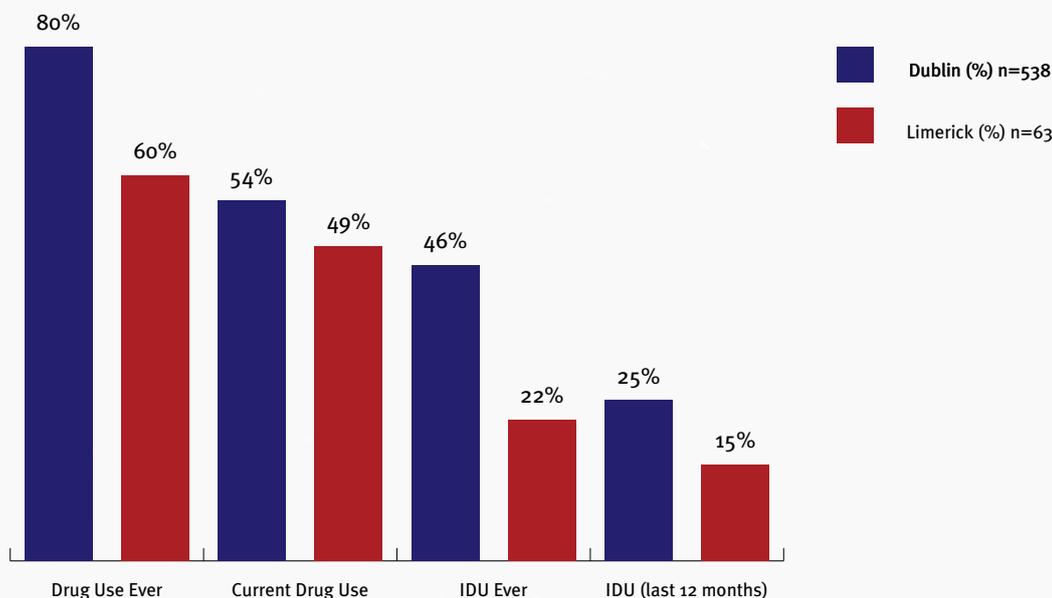
	Abstainer (last 12mths)		Drinking at least twice per week		5+ drinks per drinking occasion	
	SLAN (n=10,313)	Homeless (n=590)	SLAN (n=10,313)	Homeless (n=582)	SLAN (n=7,736)	Homeless (n=559)
<b>Total</b>	19%	18%	38%	41%	41%	68%
<b>Men</b>	15%	17%	45%	44%	54%	72%
<b>Women</b>	23%	21%	30%	34%	27%	59%
<b>18-29</b>	11%	19%	38%	25%	67%	66%
<b>30-44</b>	14%	21%	38%	41%	40%	68%
<b>45-64</b>	21%	11%	41%	59%	29%	72%
<b>65+</b>	41%	11%	28%	67%	16%	56%

## 5.5 Drug Using Behaviours

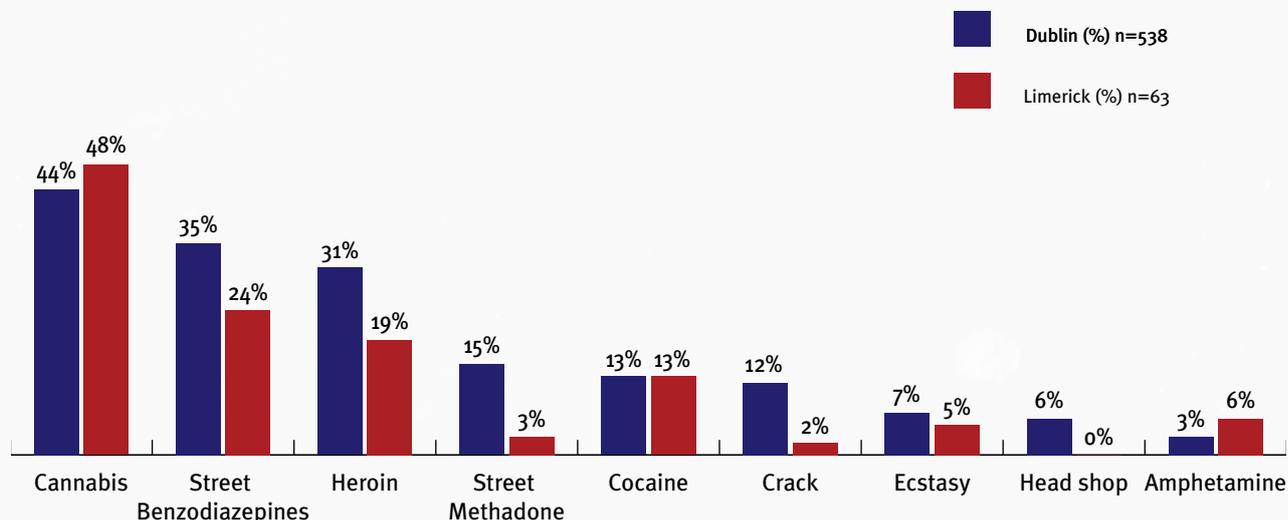
Figure 4 shows that past and current drug use was more prevalent in the Dublin sample than in the Limerick sample (80% vs. 60%). In Dublin more than half reported current drug use compared to just under half of the Limerick sample. Injecting drug use (IDU) was also more prevalent in Dublin. Current and past drug use declined with age group with the highest proportions (71% and 88% of the Dublin and Limerick samples respectively) in the 18-29 year age group. A slightly higher proportion using drugs intravenously were among the 30-44 year age group (29%) compared with 27% in the younger age group. Past injecting drug use was twice as prevalent in this middle age group as among the younger age group (27% vs 13%).

Cannabis was the drug most commonly used among current drug users followed by illicit use of benzodiazepines and heroin (Figure 5). While cannabis use was more prevalent in Limerick, heroin use was more prevalent in Dublin with one third of the Dublin sample reporting current use compared to one fifth in Limerick. Lower proportions of both samples reported current cocaine use and crack use in Limerick was rare. Methadone bought illegally was currently used by 15% of the Dublin sample and was rare in the Limerick sample. Ecstasy and amphetamine use was low. Use of 'other' drugs in the Dublin sample included LSD, mushrooms, ketamine, morphine and crystal meth.

**Figure 4: Drug use overview Dublin and Limerick**



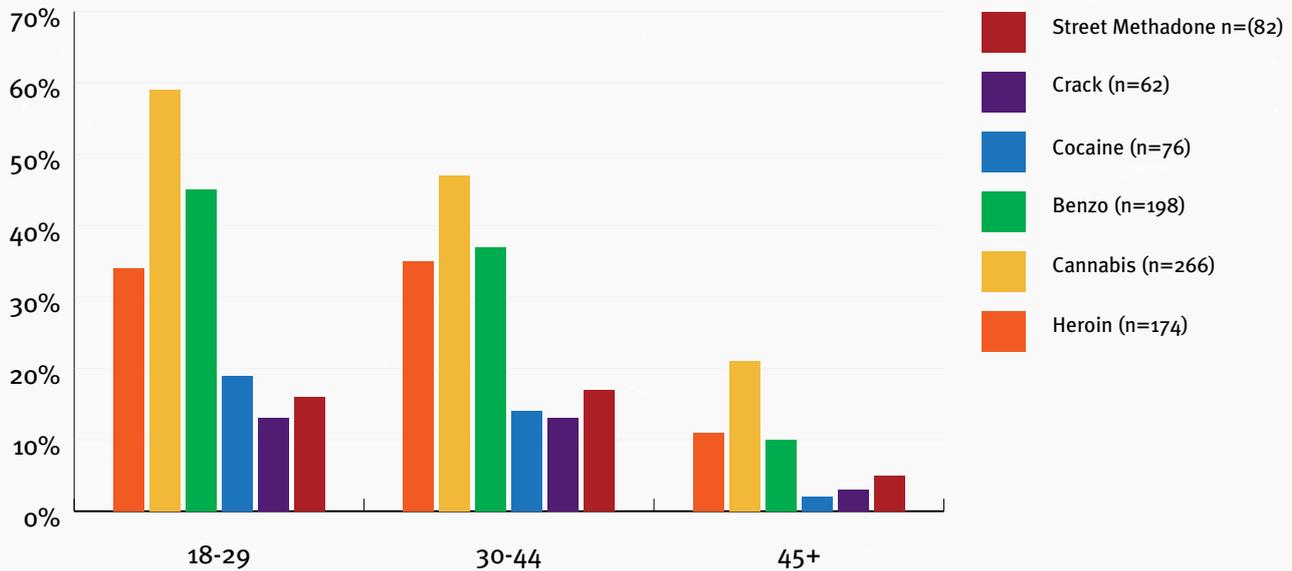
**Figure 5: Current drug use in Dublin and Limerick**



Cannabis was the most prevalent drug currently used in all age categories. Overall, more of the younger homeless people smoked cannabis and used benzodiazepines compared to the older age groups (Figure 6).

Men were more likely to be cocaine users than women but there were no other gender differences in the type of drugs people currently used.

**Figure 6: Current drug use by age group**



### 5.5.1 Current and past drug use

Table 13 on the following page displays current, past and non-use for each drug asked about in the survey. Apart from amphetamines, cannabis and cocaine, current use for each drug is higher in Dublin than in Limerick. There are higher proportions reporting current use of heroin, benzos and cannabis than past use, perhaps reflecting the difficulty in withdrawing from these drugs. Conversely, cocaine, crack, ecstasy and amphetamines have higher proportions reporting past use, perhaps suggesting experimental or dabbling use. Head shop powder use is almost all reported as past use suggesting the successful impact of the legislation banning head shops. Of note, in Limerick, for every 1 past heroin user, there are 4 current

heroin users while in Dublin the rate is almost 1 to 1. This may reflect more of a difficulty in accessing methadone in Limerick, or heroin as a newer phenomenon with users not yet moving towards methadone and away from heroin. This theme is reflected too when it comes to injecting drug use with 25% injecting in Dublin and 15% in Limerick in the last year. Nearly everyone who used drugs intravenously used heroin. However in Dublin, one third of injecting drug users also injected cocaine and small numbers reported injecting a range of other substances including head shop powders, benzodiazepines, crack, amphetamines and ecstasy.

**Table 13: Current and past illicit drug use**

		Dublin	Limerick	Total	
		n	533	63	596
Illicit drug use ever			79.9%	60.3%	77.9%
Illicit drug use last 3 months			56.1%	49.2%	55.4%
		n	531	62	593
Heroin use	Current		30.5%	19.4%	29.3%
	Past		24.9%	4.8%	22.8%
	Never		44.6%	75.8%	47.9%
		n	527	62	589
Cocaine use	Current		12.9%	12.9%	12.9%
	Past		44.4%	33.9%	43.3%
	Never		42.7%	53.2%	43.8%
		n	528	62	590
Crack use	Current		11.6%	1.6%	10.5%
	Past		27.5%	11.3%	25.8%
	Never		61.0%	87.1%	63.7%
		n	528	62	590
Street methadone use	Current		15.2%	3.2%	13.9%
	Past		20.6%	4.8%	19.0%
	Never		64.2%	91.9%	67.1%
		n	531	62	593
Cannabis use	Current		44.4%	48.4%	44.9%
	Past		24.7%	11.3%	23.3%
	Never		30.9%	40.3%	31.9%
		n	529	62	591
Benzodiazepines (street) use	Current		34.6%	24.2%	33.5%
	Past		16.3%	8.1%	15.4%
	Never		49.1%	67.7%	51.1%
		n	526	62	588
Head shop powders use	Current		6.3%	0.0%	5.6%
	Past		22.8%	21.0%	22.6%
	Never		70.9%	79.0%	71.8%
		n	529	62	591
Ecstasy use	Current		7.2%	4.8%	6.9%
	Past		45.2%	35.5%	44.2%
	Never		47.6%	59.7%	48.9%
		n	519	62	581
Amphetamines use	Current		3.3%	6.5%	3.6%
	Past		38.5%	35.5%	38.2%
	Never		58.2%	58.1%	58.2%
		n	532	62	594
Other drug use			9.0%	0.0%	18.2%
		n	511	59	570
Intravenous drug use	Within last 12 months		25.2%	15.3%	24.2%
	Past		20.7%	6.8%	19.3%
	Never		54.0%	78.0%	56.5%

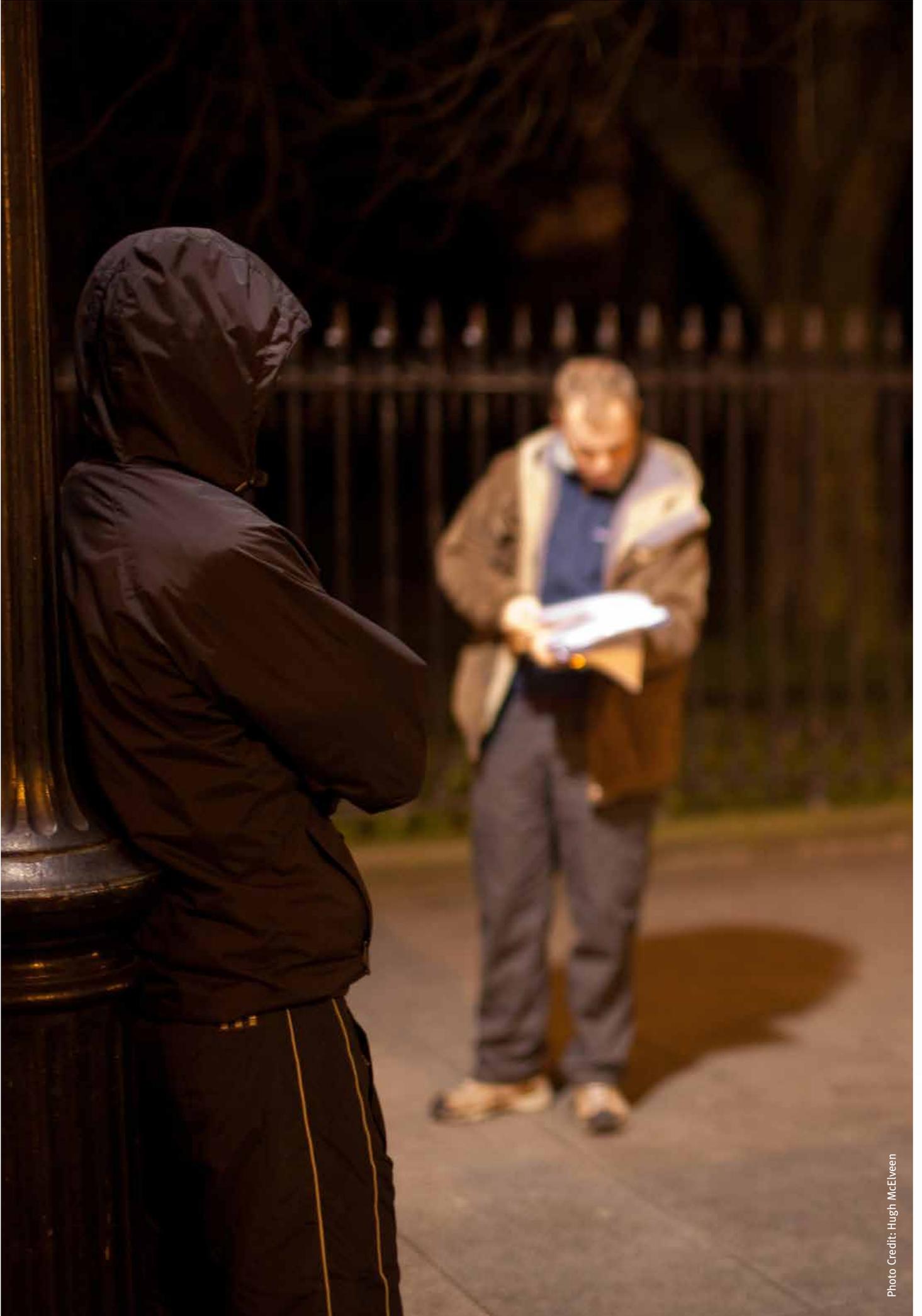


Photo Credit: Hugh McElveen

### 5.5.2 Poly drug use among current drug users

Among current drug users with information on the number of illicit drugs used in the past three months (n=323), poly drug use was the norm with 71% reporting use of more than one illicit drug. The majority of those who only used one drug in the past three months were cannabis smokers. Twenty eight percent of drug users used four or more illicit drugs in the past three months.

Over half of this cohort had been prescribed sedatives/ tranquillizers in the past or currently, 30% had been prescribed anti-psychotics and 53% methadone. Current methadone prescription among illicit drug users (current or past) was twice as common in Dublin than Limerick. Of note also is the relatively low rate of past methadone users compared to current methadone users reflective of maintenance as the treatment aim.

### 5.5.3 Use of prescription medication by illicit drug users

Current or past illicit drug users who were not rough sleeping (n=440), were asked about prescribed medication.

**Table 14: Number of drugs used in past three months**

		Dublin	Limerick	Total
n		292	31	323
Number of illicit drugs (in last 3 months)	One drug only	28.1%	41.9%	29.4%
	Two-three drugs	43.5%	35.5%	42.7%
	Four to six drugs	21.9%	19.4%	21.7%
	Seven or more drugs	6.5%	3.2%	6.2%

**Table 15: Use of prescribed medication among illicit drug users**

		Dublin	Limerick	Total
n		402	38	440*
Use of prescribed sedatives/tranquilisers	Current	39.6%	47.4%	40.2%
	Past	15.4%	7.9%	14.8%
	Never	45.0%	44.7%	45.0%
n		390	37	427*
Use of prescribed anti-psychotics	Current	19.0%	24.3%	19.4%
	Past	11.0%	0.0%	10.1%
	Never	70.0%	75.7%	70.5%
n		423	38	461
Use of prescribed methadone	Current	47.8%	23.7%	45.8%
	Past	6.9%	7.9%	6.9%
	Never	41.8%	68.4%	44.0%
	Not currently**	3.5%	0.0%	3.3%

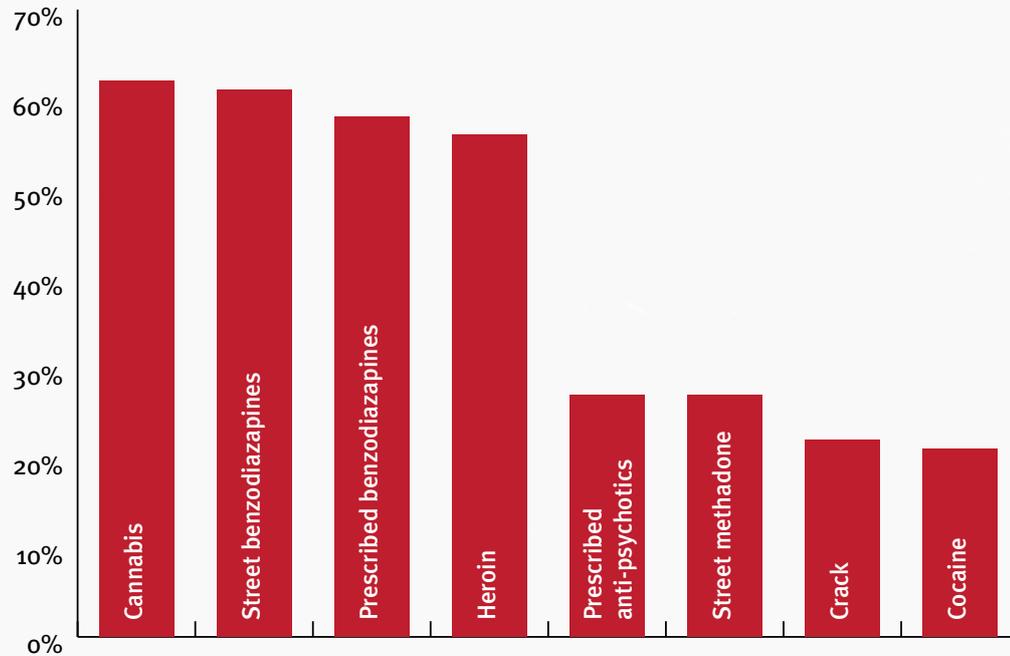
\*This question was not included in the shortened questionnaire used for Rough Sleepers

\*\*This question was changed for Rough Sleepers who were asked if they were on methadone currently or not

Prescription of sedatives and minor tranquillizers among current drug users was common (40%). One in 5 current drug users were also legally prescribed anti-psychotics. Among those currently using illicit benzodiazepines, almost half (49%) were also prescribed them legally. This suggests poor targeting of prescribed minor tranquillizers.

The following figure shows the plethora of drugs used by people reporting they were currently on methadone maintenance treatment (n=211). Here we see use of legally and illegally obtained licit and illicit substances.

**Figure 7: Drug use among those on methadone maintenance treatment (n=211)**



#### 5.5.4 Methadone prescription among heroin users

A total of 309 respondents (52%) had used heroin in the past or continued to use it. Of these, most (68%) were currently on methadone and only 32 (11%) had a history of methadone prescription but were no longer on it. Of those who had come off methadone, only 10 (31%) were no longer using heroin either. Current heroin users in Dublin were more likely to be on methadone treatment than current heroin users in Limerick which may reflect an earlier stage of the drug using career or a difficulty in accessing methadone treatment. However numbers are too small to draw inference.

#### 5.5.5 Current heroin users not on methadone

Of the 172 people currently using heroin, with information about methadone use, 53 (31%) were not on methadone treatment. The majority of these heroin users were in the Dublin sample (n=48, 91%). Less than half (n=22, 42%)

had been on methadone previously. Fourteen (61%) of the 23 rough sleepers interviewed were among this group while 34 were dispersed across various STA and PEA accommodations. Poly drug use was the default pattern of drug use among this group with the majority (n=50, 94%) using more than one drug; 34 (64%) were using 3 or more drugs. Most (n=31, 58%) were injecting drug users within the past year. Most (n=38, 72%) were male and between 30-49 years (n=35, 66%).

In 1997, methadone was not asked about, possibly reflecting the lack of services for the growing opiate problem in Dublin at the time. It was not until 1998 that the methadone maintenance protocol was put on a legal footing. The Holohan (1997) study found 134 (29%) had used illicit drugs, but type of drugs used was not recorded. Of those reporting illicit drug use, 68% had used addiction services.

**Table 16: Methadone prescription among heroin users**

		Dublin	Limerick	Total
Past or current heroin users	n	291	15	306
Prescribed methadone	Current	68.4%	60.0%	68.0%
	Past	10.0%	20.0%	10.5%
	Never	16.5%	20.0%	16.7%
	not currently*	5.2%	0.0%	4.9%
Current heroin users	n	160	12	172
Prescribed methadone	Current	70.0%	58.3%	69.2%
	Past	11.9%	25.0%	12.8%
	Never	9.4%	16.7%	9.9%
	not currently*	8.8%	0.0%	8.1%

\*This question was changed for Rough Sleepers who were asked if they were currently on methadone rather than their history of methadone treatment



Photo Credit: Hugh McElveen

The 2005 survey demonstrated that the drug problem had become more visible as had the response in terms of methadone treatment. In 2005, twice the proportion (64%) reported they had used illicit drugs compared to 1997. Seventy percent of those reporting heroin addiction were in receipt of methadone treatment in 2005. In 2013, 80% reported having used illicit drugs and 77% percent of those reporting heroin addiction reported receipt of methadone treatment. This suggests an increase in treatment coverage. In 2005, three quarters of those receiving methadone attended clinics with 16% attending GPs and 9% getting methadone treatment from a mobile unit. In 2013, the structure of methadone provision for the homeless had not changed radically with most (78%) attending clinics, 16% attending GPs and 6% attending outreach GPs (Safetynet service). Of those reporting an opiate problem, numbers waiting for methadone treatment in both surveys was low (n=12, 10%) in 2005 and in 2013 (n=10, 6%).

## 5.6 Self-Reported Drug or Alcohol Problem

Overall, of those asked, 415 (73%) reported a drug or alcohol problem. This was higher for Dublin respondents compared with Limerick (74% vs. 60%).

## 5.7 Main Drug or Alcohol Problem

Of those reporting their main problem substance (n=412), 59% reported addiction to drugs while 41% reported that their main addiction substance was alcohol. A similar proportion (41%) reported opiates as their main addiction. A higher proportion of the Limerick sample saw alcohol as their main addiction compared to the Dublin sample. While minor tranquillizers and cannabis use was quite prevalent, only 8% and 5% respectively saw these as their main drug problem. The most significant drugs of addiction reported were alcohol and opiates. Among those reporting heroin addiction, similar proportions of current heroin users (76%) reported methadone prescription as past heroin users (75%).

**Table 17: Self-reported main problem drug**

		Dublin	Limerick	Total	
		n	374	38	412
Main problem drug	Alcohol	39.6%	57.9%	41.3%	
	Opiates	43.6%	15.8%	41.0%	
	Cannabis	4.0%	13.2%	4.9%	
	Minor tranquilizers (tablets)	8.0%	10.5%	8.3%	
	Cocaine/crack	3.2%	2.6%	3.2%	
	Other	1.6%	0.0%	1.5%	

## 5.8 Addiction Services

People who believed they had a drug or alcohol problem were asked if they had used particular drug services (counselling, needle exchange, inpatient detox, rehabilitation, aftercare and stabilization). Most (78%) had used one of these services in the previous 12 months. Forty three percent had used a detox, rehab or aftercare service for an alcohol problem at some stage in the past. More of the Limerick sample (57%) had received these services than the Dublin sample (41%) which fits with the profile of more alcohol addiction among the Limerick sample and more drug use among the Dublin sample.

Counselling was the most utilised service by people who believed they had a drug or alcohol problem with almost half (45%) of respondents saying they had received it in the past year and over one third (38%) reporting having received it in the past six months. Similar proportions of injecting drug users used needle exchange in both Dublin (74%) and Limerick (75%). However, this equates to just 6 people in Limerick compared with 77 people in Dublin. Inpatient Detox in the past year had been used by 18% who believed they had an addiction problem and a similar proportion used a rehab or a stabilisation service. Twelve percent used an aftercare service. Seventy three respondents reported waiting for a particular drug addiction service (30 waited for inpatient detox, 17 for a drug rehabilitation service, 15 for counselling and 8 for stabilization and 3 for aftercare).

Most people (71%) with an addiction problem reported being linked in with some addiction service including methadone, now or in the last 6 months. The majority (89%) of those with an opiate addiction reported using an addiction service including the methadone service within the last 6 months. This represents a vast improvement since 1997 when 37% reporting illicit drug use reported attending some addiction service in the past 6 months (specific services were not asked about). In 2005, a similarly high proportion of those reporting an opiate addiction problem (89%) reported receipt of either methadone, needle exchange, counselling or inpatient detox in the past 6 months.

## 5.9 Changes Over Time

Figure 8 on the following page shows the increase in the number of homeless people in Dublin reporting current or past illicit drug use over time. Current drug use was not recorded in 1997 and while it was recorded in 2005, it was not validated by asking about specific drugs used in the past three months as in 2013. This means that there may have been an under report of current drug use in 2005 as respondents who smoked cannabis, for example, may not have considered themselves as current drug users. Nevertheless, reporting of current illicit drug use more than doubled in 2013 to 56% from 23% in 2005. The type of illicit drugs used among the young populations (<25 years) shows that fewer had a history of using heroin in the 2013 survey (40%) compared to the 2005 survey (60%). However, it appears that benzodiazepine use among this age group has increased (60%) compared to 48% in 2005. Unfortunately, cannabis was not specifically asked about in 2005. However, the majority (79%) of the 2013 sample reported having used this drug.

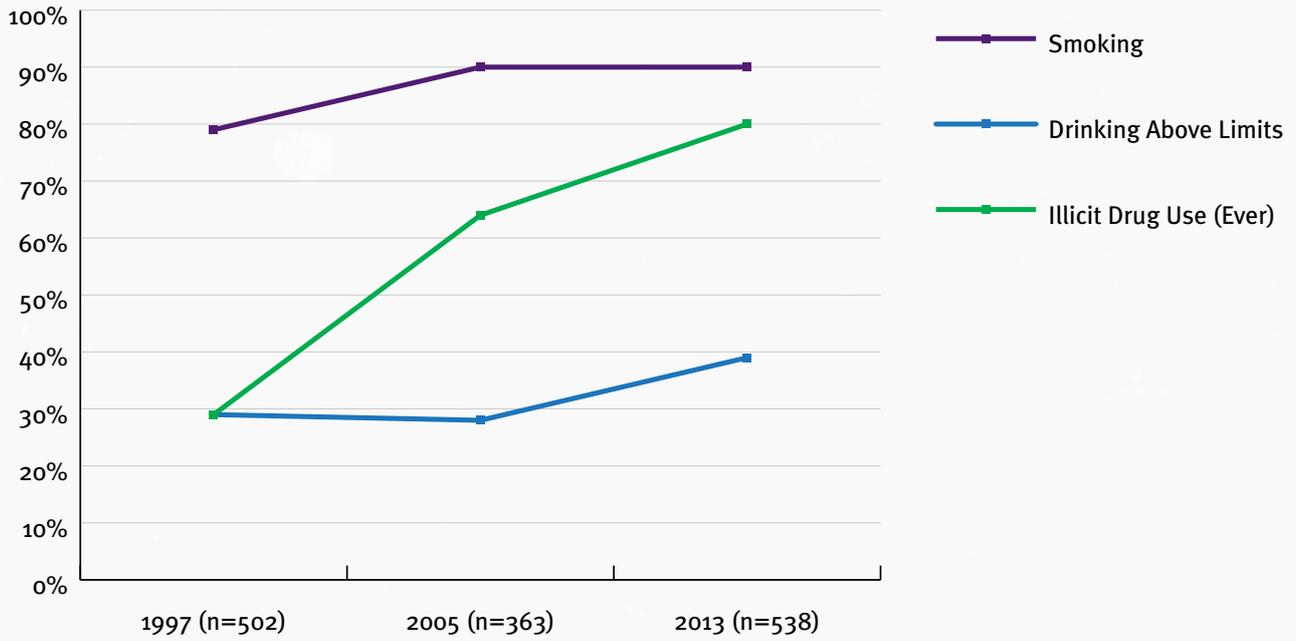
Drinking above recommended weekly limits<sup>5</sup> also increased over time as did cigarette smoking so that now almost everyone reported smoking at the time of interview.

Figure 9 compares 'ever use' of specific drugs reported in 2005 and 2013. More reported a history of cocaine, benzodiazepine and street methadone use in 2013.

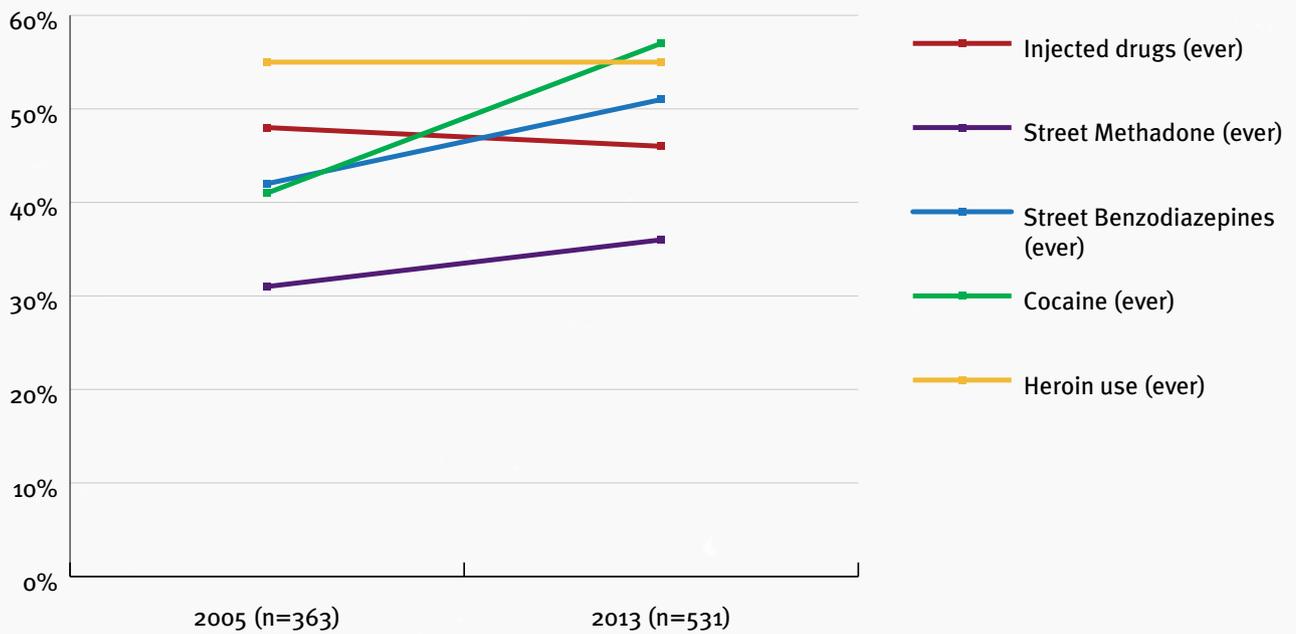
In Dublin the proportion who believed they had an addiction problem rose for 62% of the sample in 2005 to 73% in the 2013 sample. More described their main addiction as Heroin in 2005 compared to 2013 (51% vs 43%), while more in 2013 reported alcohol as their main problem substance than in 2005 (40% vs 24%).

<sup>5</sup> The previous older limits are used here (21 units for men and 14 for women) so that they can be compared with the older studies.

**Figure 8: Change in addiction patterns in Dublin**



**Figure 9: Changes in drug using patterns in Dublin**



## 5.10 Summary

The number of respondents reporting a history of illicit drug use has steadily risen since 1997. Over time, addiction patterns have changed among the homeless population; from alcohol and some drug use to widespread opiate use and now poly drug use, with much cannabis and minor tranquillizer abuse. There is also an increase in rates of dangerous drinking, particularly among women, who have caught up with men's dangerous alcohol consumption. Though smoking among the homeless was always highly prevalent it has become almost universal.

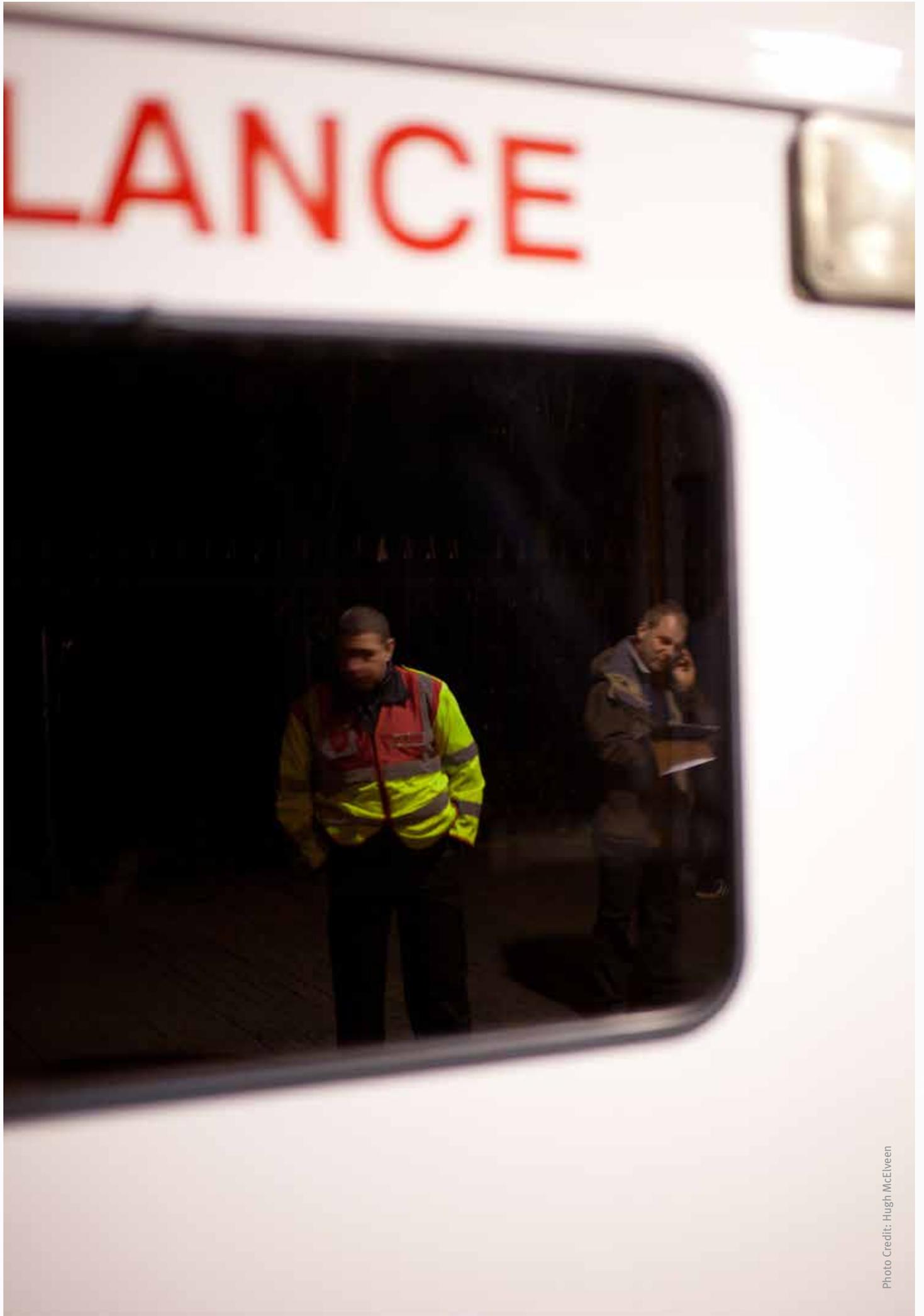
Most people with a heroin addiction were on methadone but almost a third of current heroin users were not on a methadone programme. While there was an increase in treatment coverage in Dublin since the last survey, the structure of provision has not changed, with the majority of homeless people attending clinics rather than primary care for treatment. The majority of people on methadone reported also using illicit drugs including heroin. However, most of those who no longer used heroin were currently on methadone suggesting it is difficult to

give up heroin without it. There was a high rate of concurrent use of illegal drugs obtained illegally, legal drugs obtained illegally and legal drugs obtained legally with half of those abusing benzodiazepines also being prescribed them legally.

Heroin use in Limerick appears as a newer phenomenon. There were fewer current users and a far lower prevalence of past users than in Dublin. Current users are slightly less likely too to be on a methadone programme in Limerick. More than three quarters who reported an addiction problem had used a non-medical addiction service in the past year indicating a high rate of addiction service use.

Findings suggest a high level of poly drug misuse among homeless people and good methadone treatment coverage. However, there may be a need to increase coverage among rough sleepers given the lower coverage rates.





# 6. Health

## Highlights

Respondents were asked about their perceptions of their health status, use of prescribed medication and use of services for women's health. They were asked if they had received specific diagnoses by a doctor and whether they had received treatment for these. Respondents were also asked about their experience of self-harm and suicidality.

- Almost half of the sample perceived their health as only fair or poor and many perceive their health as declining over the past year.
- Mental and physical morbidity has increased over time with almost all reporting having mental or physical health problems.
- The most common physical health problems were dental problems, Hepatitis C (in Dublin), peptic or stomach conditions, asthma, high blood pressure, respiratory disease and liver disease. However, mental health problems were even more common, with depression the most commonly diagnosed single condition followed by anxiety.
- In general, the majority who reported a diagnosis for an illness or condition also reported having received treatment.
- Most were in receipt of prescription medication and were on long-term medication.
- Almost half the sample experienced both mental health issues and addiction problems.
- More than half the sample had previously experienced suicidal thoughts and more than a third had attempted suicide.
- Compared to 1997, the homeless population has more diagnosed ill-health; more are treated with prescribed medication, and more report mental health diagnoses and treatment also.

## 6.1 Self-Report on Health Status

Respondents were asked a series of questions related to their self-perceived health status. Almost half the sample in both Dublin and Limerick stated their health was only fair or poor. Almost one quarter (24%) rated it as poor. This compares to 10% of the general population rating their health as poor, bad or very bad (CSO, Special Report, 2012). The result from this study is slightly lower than the findings from the 2005 study where 54% of the homeless population involved in the study rated their health as fair or poor (O'Carroll and O'Reilly, 2008). The 1997 homeless study found 44% rated their health as fair or poor (Holohan, 1997), suggesting no real change in the self-perceived health status of the homeless. Nearly 40% of the full sample reported a decline in their health status over the past year. This is largely in keeping with findings from 2005 (O'Carroll & O'Reilly, 2008).

Despite high levels of perceived poor health, one fifth of the Dublin sample and one quarter of the Limerick sample perceived their health as very good or excellent and more of the Limerick sample (43%) experienced an improvement in their health over the past year compared to the Dublin sample (34%).

Physical and mental health problems may affect one's capacity to engage in normal daily activities. Where this occurs, the health problem intrudes on the individual's

life. This study found both physical and mental health problems were intrusive in the lives of those in the sample, with 52% stating that mental and emotional problems and 46% stating that physical health problems affected their daily activities. Compared to the 2005 Dublin homeless study this shows a slight increase in those noting that their health status prevented normal daily activities.

In Limerick, physical health problems and mental or emotional health problems were equally likely to prevent engagement in normal daily activities, while in Dublin, mental or emotional health problems were slightly more likely (53% vs 47%) to prevent normal daily activities. More of the Dublin sample reported that mental health problems affected their daily lives compared to the Limerick sample (53% vs 40%).

Self-rated fair or poor health (as opposed to good, very good or excellent) was not associated with gender. However, it was associated with increasing age, self-report of diagnosis with a physical or mental health condition, and current use of prescription medication. A higher proportion of those on methadone reported fair or poor health compared to those not on methadone. Though fair/poor health status was associated with injecting drug use, it was not associated with current or past illicit drug use in general. Those who had increased alcohol consumption also were more likely to report fair or poor

**Table 18: Self-rated health status and change**

		Dublin	Limerick	Total	
		n	537	63	600
Self-rated health status	Very good or excellent	19.0%	25.4%	19.7%	
	Good	34.3%	27.0%	33.5%	
	Fair or poor	46.7%	47.6%	46.8%	
		n	532	61	593
Health status change over the last year	Better	33.6%	42.6%	34.6%	
	Same	27.4%	16.4%	26.3%	
	Worse	38.9%	41.0%	39.1%	
		n	537	63	600
Preventing normal daily activities	Physical health	46.9%	38.1%	46.0%	
	Mental or emotional health	52.9%	39.7%	51.5%	

health. Higher prevalence of fair or poor health was found among those who had attended at A&E or at a specialised homeless health service in the past 6 months as well as those who had a hospital inpatient stay.

## 6.2 Overview of Morbidity

The vast majority of the sample (89%) had some form of diagnosed health condition. This demonstrates a slight increase since 2005 when O’Carroll and O’Reilly (2008) found that 84% of the homeless sample in Dublin had some form of physical or mental morbidity and an increase on the 67% who reported a physical or mental health problem in 1997 (Holohan, 1997).

In general, the health of the Dublin sample was worse than that of the Limerick sample with the exception of mental illness where almost 60% of both samples reported a mental health diagnosis. Chronic or minor physical conditions were the most common illness in both the Dublin sample (83%) and the Limerick sample (67%). While nearly one third of the Dublin sample suffered from blood borne viruses, no one in the Limerick sample did. The differences between the Dublin and Limerick sample were statistically significant in relation to the rates of chronic physical conditions, blood borne viruses and acute physical conditions.

**Table 19: Categorized health conditions**

		Dublin	Limerick	Total
	n	536	63	599
<b>Morbidity</b>	Either mental or physical diagnosis	89.6%	82.5%	88.8%
	At least one mental health diagnosis	58.4%	58.7%	58.4%
	Any chronic or minor physical health diagnosis	82.8%	66.7%	81.1%
	Chronic physical health diagnosis (Diabetes Mellitus, High Blood Pressure, Arthritis, Heart Disease, Epilepsy, Tuberculosis, Chronic Respiratory & stomach problems)	69.2%	55.6%	67.8%
	Blood borne viruses	30.6%	0.0%	27.4%
	Minor physical conditions (teeth, feet, skin)	60.4%	36.5%	57.9%



### 6.3 Physical Health Conditions

Participants were asked if they had received specific diagnoses and whether they had received treatment for these. The full list is provided in Table 20 below. Across the sample, peptic or stomach conditions, asthma, high blood pressure, respiratory disease and liver disease were the most commonly diagnosed physical health conditions. Some differences were also noted between Dublin and Limerick: those in Dublin had higher rates of high blood pressure and peptic or stomach conditions, while those in Limerick had higher rates of epilepsy. Most notably, while 16% of the Dublin sample had been diagnosed with liver disease only one person in the

Limerick sample had. This may represent an under diagnosis in Limerick given that there are more drinkers in the Limerick sample.

In both Dublin and Limerick, most who had been diagnosed with a condition also reported receiving treatment for that condition. However, those in Dublin received treatment for their diagnosed condition somewhat less often for all conditions than those in Limerick, with the exception of arthritis. This was particularly notable for high blood pressure where 19% had been diagnosed and 12% had been treated in Dublin, whereas in Limerick all those who had been diagnosed

**Table 20: Self-report of diagnosed and treated conditions**

	Dublin	Limerick	Total
n	536	63	599
Diagnosed with Diabetes	2.6%	3.2%	2.7%
Treated for Diabetes	2.2%	3.2%	2.3%
Diagnosed with High Blood Pressure	18.5%	9.5%	17.5%
Treated for High Blood Pressure	12.1%	9.5%	11.9%
Diagnosed with Arthritis	10.8%	6.3%	10.4%
Treated for Arthritis	6.3%	3.2%	6.0%
Diagnosed with Epilepsy	7.6%	14.3%	8.3%
Treated for Epilepsy	6.5%	14.3%	7.3%
Diagnosed with TB	2.6%	0.0%	2.3%
Treated for TB	2.6%	0.0%	2.3%
Diagnosed with Respiratory Disease	17.5%	9.5%	16.7%
Treated for Respiratory Disease	15.5%	9.5%	14.9%
Diagnosed with Asthma	25.0%	31.7%	25.7%
Treated for Asthma	22.9%	31.7%	23.9%
Diagnosed with peptic or stomach problems	27.2%	17.5%	26.2%
Treated for peptic or stomach problems	21.5%	17.5%	21.0%
Diagnosed with Heart Disease	7.5%	7.9%	7.5%
Treated for Heart Disease	6.7%	6.3%	6.7%
Diagnosed with Liver Disease	15.6%	1.6%	14.2%
Treated for Liver Disease	10.2%	0.0%	9.1%

reported receiving treatment. In Dublin, 16% had been diagnosed with liver disease while 10% reported receiving treatment.

Although the prevalence of many of the conditions reported by the study sample has remained relatively steady since 1997 and 2005, there are some notable changes: the prevalence rate of peptic ulcers and stomach conditions had nearly doubled since 1997 (Holoan, 1997).

Report of a diagnosis with one of the listed physical conditions was more common among current or past drug users and older age groups. There were no gender differences found. Report of diagnosis with one of the listed chronic conditions increased with age as would be expected.

## 6.4 Blood Borne Viruses

Blood borne viruses, such as HIV, Hepatitis C and Hepatitis A are more common among the homeless than the general population (Beijer et al., 2011). Although no one in the Limerick sample reported suffering from a blood

borne virus, more than one third of the Dublin population had a blood borne virus. Hepatitis C was most common with more than a quarter of the Dublin sample diagnosed with this virus. However, this is a reduction since 2005 where 36% of the Dublin homeless sample reported having Hepatitis C (O'Carroll and O'Reilly, 2008). Nevertheless, this is significantly higher than among the general Irish population where there is a prevalence rate of less than 2% (Health Services Executive [HSE], 2012). HIV (4%) and Hepatitis B (5%), rates remained similar to 2005 (O'Carroll and O'Reilly, 2008). All those who were diagnosed with HIV reported having received treatment, compared to just over half of those with Hepatitis B. Among those diagnosed with Hepatitis C, almost three quarters had been assessed or offered treatment and just over half reported having received treatment, nevertheless, a cohort of people remain untreated.

Report of a diagnosis with blood borne viruses including Hepatitis C was more common among current and past drug users as would be expected.

**Table 21: Self-report of diagnosed and treated blood borne viruses**

		Dublin	Limerick	Total
	n	531	63	594
Diagnosed with HIV		3.6%	0.0%	3.2%
Treated for HIV		3.6%	0.0%	3.2%
	n	525	63	588
Diagnosed with Hepatitis B		4.8%	0.0%	4.3%
Treated for Hepatitis B		2.9%	0.0%	2.6%
	n	530	62	592
Diagnosed with Hepatitis C		28.5%	0%	25.5%
Of those Hepatitis C positive	n	151	0	151
	Treated for Hepatitis C	53.0%	0.0%	53.0%
	Assessed for treatment or offered treatment	73.5%	0.0%	73.5%

## 6.5 Skin, foot and dental problems

Problems with skin, feet and teeth are common among the homeless. Among the sample in this study, almost one fifth reported problems with their feet with 12% receiving treatment for these problems. Skin ulcers, wounds and infections were somewhat less common, experienced by 14% of the study sample. Almost all those who had such conditions reported having received treatment.

Dental problems were more than twice as common among the Dublin sample compared to the Limerick sample. There was also an increase of more than 10% in the numbers of individuals reporting dental problems since 1997 (Holohan, 1997). The increase since 1997 and among Dublin rather than Limerick homeless is likely a result of the increase in drug use over time in Dublin. Chaotic lifestyles associated with substance misuse do not favour

regular dental or medical care, and many patients have a poor standard of general health as a result. Also, methadone, as well as other opiates, cause dry mouth, which further compounds the problem of plaque retention. Methadone formulations can have high acid content making erosion a risk (Green & Pynn, 2011). Over one quarter of both the Limerick and Dublin homeless who reported having teeth problems also reported not receiving dental treatment.

Dental problems were much more commonly reported among current and past drug users and among women. It is possible that women were more aware of dentition and therefore more likely to seek treatment and report problems.

**Table 22: Skin, foot and dental problems**

	Dublin	Limerick	Total
n	535	63	598
Diagnosed with foot problems	17.4%	14.3%	17.1%
Treated for foot problems	12.5%	9.5%	12.2%
n	536	63	599
Dental problems	51.7%	22.2%	48.6%
Treated for dental problems	37.1%	15.9%	34.8%
n	486	63	549
Skin, ulcers wounds and infections	14.4%	14.3%	14.4%
Treated for skin problems	13.1%	14.3%	13.2%

## 6.6 Women's Health

Only 1 in 3 of the sample was female. However, it was possible to assess some aspects of access to women's health care among the female homeless sample, including antenatal care and pap smear tests. Among those who had previously had children, it was found that the majority in Dublin and all in Limerick had previously had antenatal check-ups while pregnant.

The majority of homeless women in Dublin (68%) and in Limerick (85%) have had a smear test at some point in their lives. The breakdown of the number of years since the last smear test is given in Table 23 on the following page. Similar proportions in Dublin and Limerick had a smear test within the previous three years. The results suggest that while women appear to be accessing care, given that everyone should have had at least one smear in the past three years, there is room for increased uptake.

**Table 23: Antenatal care and smear testing**

		Dublin	Limerick	Total
Pregnant while homeless	n	49	3	52
	Antenatal check-ups	83.7%	100.0%	84.6%
Women reporting on smear tests	n	156	14	170
	Ever had a smear test	67.9%	85.7%	69.4%
No. of years since smear test	n	100	10	110
	1yrs	37.0%	50.0%	38.2%
	2yrs	20.0%	10.0%	19.1%
	3yrs	12.0%	10.0%	11.8%
	4yrs	15.0%	0.0%	13.6%
	5+yrs	16.0%	30.0%	17.3%

### 6.7 Self-Report of Undiagnosed Illness

While the homeless in this study reported receiving clear diagnoses for a variety of conditions, some may also suffer from physical and mental health problems which have not been diagnosed or treated. This study found that a quarter of the homeless sample reported undiagnosed health problems and more than twice as many

respondents in Dublin reported experiencing an undiagnosed health problem compared to Limerick. Of those in Limerick who did report an undiagnosed health problem, half stated they had mental health symptoms and half had physical health problems. In Dublin, just over half had physical symptoms and approximately one third had mental health symptoms.

**Table 24: Undiagnosed health problems**

		Dublin	Limerick	Total
	n	486	63	549
Undiagnosed health problems		27.2%	12.7%	25.5%
	n	132	8	140
Mental health symptoms		35.6%	50.0%	36.4%
Physical symptoms		53.0%	50.0%	52.9%
Both physical & mental health symptoms		4.5%	0.0%	4.3%
Unspecified		6.8%	0.0%	6.4%

## 6.8 Mental Health

Mental illness was common among the study sample. Just over half of the sample had been diagnosed with depression, with the majority of these reporting they had received treatment for their diagnosed depression. Anxiety disorders were also very common; almost half of the Limerick sample and over a third of the Dublin sample had received a diagnosis for this mental condition. Again, most of those who had been diagnosed reported receipt of treatment.

Of note, the prevalence of reported anxiety and depression has increased significantly since 1997: from 28% to 39% for anxiety and from 33% to 52% for depression (Holohan, 1997). However, in 2013 the rate is similar to the 2005 survey (42% for anxiety and 51% for depression). This increase from 1997 to 2005 may be related to the increase in drug misuse which could cause anxiety or depression. The increase may also reflect changes in access to medical/psychiatric care resulting in increased diagnosis by 2005 or indeed a reduction in access to institutional care for people with mental health conditions. Changes which may have increased the likelihood of

diagnosis by 2005 include the increase in GP outreach services in homeless hostels and the increase in psychiatry-led addiction services as part of the methadone maintenance protocol. The decommissioning of the St Brendan's Hospital programme for homeless may have decreased other accommodation or care options for homeless people. This will be discussed further in the service utilisation section.

Schizophrenia or psychosis was less common than depression or anxiety in this study (13%). However, this rate is considerably higher than the rate in the general population, where an estimated 1% is affected by schizophrenia in Ireland (College of Psychiatrists of Ireland). All those with schizophrenia or psychosis in Limerick and 90% in Dublin had received treatment.

Report of a diagnosis of at least one of the listed mental health conditions was more common among current and past drug users and women.

**Table 25: Self-report of diagnosed and treated mental health conditions**

	Dublin	Limerick	Total
n	530	63	593
Diagnosed with anxiety	38.7%	47.6%	39.6%
Treated for anxiety	31.5%	41.3%	32.5%
n	533	63	596
Diagnosed with depression	52.3%	52.4%	52.3%
Treated for depression	43.7%	46.0%	44.0%
n	531	63	594
Diagnosed with schizophrenia or psychosis	12.4%	12.7%	12.5%
Treated for schizophrenia or psychosis	11.3%	12.7%	11.4%
n	509	63	572
Mental health diagnosis and self-diagnosed addiction problem	47.2%	44.4%	46.9%
n	533	63	596
Mental health diagnosis and currently illicit drug use	34.9%	31.7%	34.6%

## 6.9 Suicide: Attempts, Thoughts and Self-Harm

Depression and anxiety constitute important risk factors for suicide and self-harm (Haw et al., 2001), particularly when combined with other stresses and harmful substance misuse (Hilt & Lloyd-Richardson, 2008). Suicide and self-harm were both relatively common experiences for the homeless in this study in Dublin and Limerick. This is consistent with a number of studies that have noted the higher incidence of self-harm, suicidal thought, and attempted suicide among homeless populations compared to non-homeless populations, particularly in connection with mental health problems (Bickley et al., 2006; Eynan et al., 2002).

In this study, over one third of the sample had self-harmed at some point in the past, with 13% self-harming in the past six months. This compares to the general Irish population where reports of self-harm for 2012 were 211/100,000 or 0.2% (Griffin et al., 2012). Given that these statistics represent reported cases, it is likely that self-harm is underestimated in the general population, but the rate of self-harm in the homeless sample is still striking.

Suicidal thoughts were very common. More than half the Dublin sample reported experiencing suicidal thoughts at some point in the past with 29% having had suicidal

thoughts in the past six months. The Limerick sample demonstrated an even greater percentage who experienced suicidal thoughts at some point (70%) with 27% having suicidal thoughts in the past 6 months.

Suicide attempts were also common. More than a third of the sample had attempted suicide at some point in the past, with approximately 10% in both Dublin and Limerick attempting suicide in the past six months. Similarly high rates of suicide attempts have also been found among homeless samples in Canada, Australia and the US (Hodgson et al., 2014).

Report of attempted suicide was more common among current or past drug users, under 45 year olds and among women. In the general population, men are more likely to commit suicide (HSE, 2006). However, the gender difference which sees higher rates of women attempting suicide and men committing suicide is recognised in the literature (Younes et al., 2015; Griffin et al., 2012). Suicide attempt was most common among those who reported a diagnosis with a mental health condition. One in two people with a mental health condition reported having attempted suicide in the past compared to one in six of those who did not report having been diagnosed with a mental health condition. There was an increased report of attempted suicide among the long-term homeless defined as homeless for over 6 months.

**Table 26: Self-report of self-harm, suicidal thoughts and attempted suicide**

		Dublin	Limerick	Total	
		n	523	61	584
Self-harm	In the past 6 months	13.6%	11.5%	13.4%	
	Prior to past 6 months	24.1%	29.5%	24.7%	
	Never	62.3%	59.0%	62.0%	
		n	530	63	593
Suicidal thoughts	In the past 6 months	28.7%	27.0%	28.5%	
	Prior to past 6 months	26.6%	42.9%	28.3%	
	Never	44.7%	30.2%	43.2%	
		n	526	63	589
Attempted suicide	In the 6 months	9.9%	11.1%	10.0%	
	Prior to past 6 months	24.9%	34.9%	26.0%	
	Never	65.2%	54.0%	64.0%	

## 6.10 Medication

Over 60% of the study sample, in both Dublin and Limerick, were taking prescription medication. This is an increase from 49% in 2005 and 34% in 1997 (O'Carroll and O'Reilly, 2008). Two thirds (68%) of those with a mental health diagnosis who answered this question (n=311), said they had being prescribed medication for it.

All of the Limerick sample who were on prescription medication were on the medication long-term (defined

as more than 4 weeks) as were the majority of the Dublin population. More of the Limerick sample was on prescription medication than the Dublin sample.

Being on long-term prescribed medication was more common among those who reported a mental or physical health condition and past drug users. Long-term medication was least common among younger respondents (under 30 years).

**Table 27: Prescribed medication**

		Dublin	Limerick	Total
	n	535	63	598
Prescribed medication		61.3%	71.4%	62.4%
Prescribed long-term medication		58.3%	71.4%	59.7%
Diagnosed with anxiety/depression/schizophrenia	n	278	33	311
Prescribed medication for anxiety, depression or schizophrenia		67.3%	69.7%	67.5%

## 6.11 Changes Over Time

Although the self-perceived health status of the homeless in this study shows only a small change since 1997, some aspects of the health of the homeless population have demonstrated greater change between 1997, 2005 and 2013. As shown in Figure 10 on the following page, the proportion of homeless people who had diagnosed illnesses had increased between 1997 and 2005 and again in 2013.

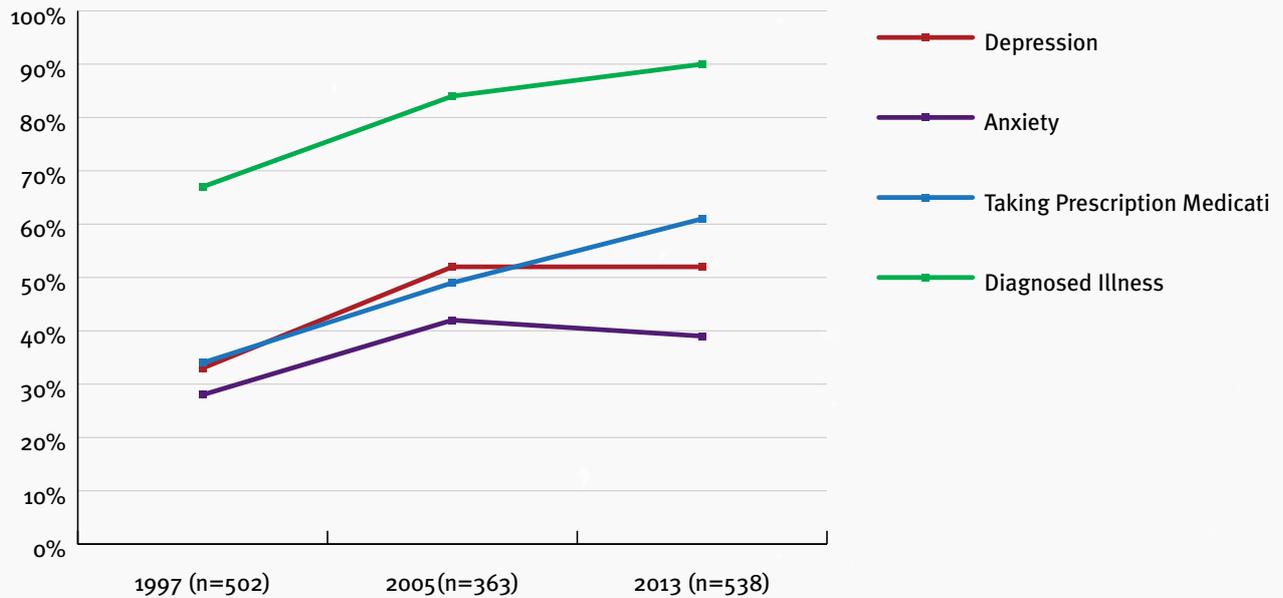
Of the specific physical health conditions reported by the homeless samples, peptic ulcers and stomach conditions demonstrate a notable change. The percentage of the homeless who suffered from these conditions has nearly doubled since 1998, from 14% to 26%. However, the 1997 study asked only about 'peptic ulcer disease' so it is possible that some responses on stomach conditions in the present study would not have been accounted for in the 1997 study, potentially reducing the difference in the rates.

There was also an increase in the numbers of individuals reporting dental problems by more than 10% since 1997 (Holohan, 1997). This is in line with an increased prevalence of opiate use which affects dentition negatively.

In the current study, 62% of the homeless were on prescription medication, this figure thus shows a notable increase from 34% in 1997 (Holohan, 1997) and 49% in 2005 (O'Carroll and O'Reilly, 2008). This may be reflective of increased access to diagnosis and treatment through specialised services for homeless people established since 1997.

Of note, the prevalence of reported anxiety and depression has increased significantly since 1997; from 28% to 39% for anxiety and from 33% to 52% for depression (Holohan, 1997). This increase may reflect changes in access to medical care resulting in increased diagnosis. The results are similar to those found in 2005 (42% for anxiety and 52% for depression) (O'Carroll and O'Reilly, 2008).

Trends among the health of the homeless suggest that the homeless are better able to access diagnostic care and treatment in the form of prescription medication. Most forms of ill health appear to have increased over time, with mental health morbidity increasing from 1997 to 2005 and then remaining stable. This may reflect an actual worsening of health of homeless people or an increase in access to diagnosis between 1997 and 2005.

**Figure 10: Health trends over time**

## 6.12 Summary

Mental and physical health problems can be both a cause and an outcome of homelessness. It is unsurprising that this study, like other studies, has found that the homeless people have higher rates of a range of illnesses and morbidity compared to the general population. Almost the entire sample (89%) had either a mental or physical health problem which had been diagnosed, with the majority also receiving treatment for ill health.

The homeless in the samples tended to perceive their health negatively and just under 40% reported a decline in their health over the past year. The health issues experienced affected the daily activities of approximately half the sample. The results indicate that health problems have a serious impact on the lives of the homeless. Mental health issues were very common, and are commonly associated with addiction problems. In fact, almost half of the sample had both a mental health problem and a self-reported addiction problem and just over a third had both a mental health problem and were currently using illicit drugs.

Rates of self-harm, suicidal ideation and attempted suicide are all elevated among this population; more than a third of the study population had self-harmed, three fifths have had suicidal thoughts and more than a third have attempted suicide, indicating the significant risk posed to homeless populations by these thought patterns

and behaviours. Half of those reporting a mental health diagnosis also reported having attempted suicide. Furthermore addiction and the length of time spent homeless were also associated with attempted suicide. The direction of the relationship between these issues is unclear – mental health issues may create vulnerability to drug addiction, homelessness and suicidal ideation. Homelessness may also make one more vulnerable to drug addiction and mental health problems, and drug addiction may lead to homelessness, and so on. Longer length of time spent homeless is likely an aggravating factor for all these health conditions. It is likely that relationships between these issues are inter-linked with a need for programmes and interventions to target multiple risk-factors among the homeless and among those at-risk of homelessness.

The study indicates that homeless populations have clear health needs with a greater likelihood of experiencing a number of forms of morbidity. Drug and alcohol addiction and mental health issues present as the most pressing of health concerns and are associated with secondary health problems also found elevated among this population, such as liver disease, dental problems and Hepatitis C.

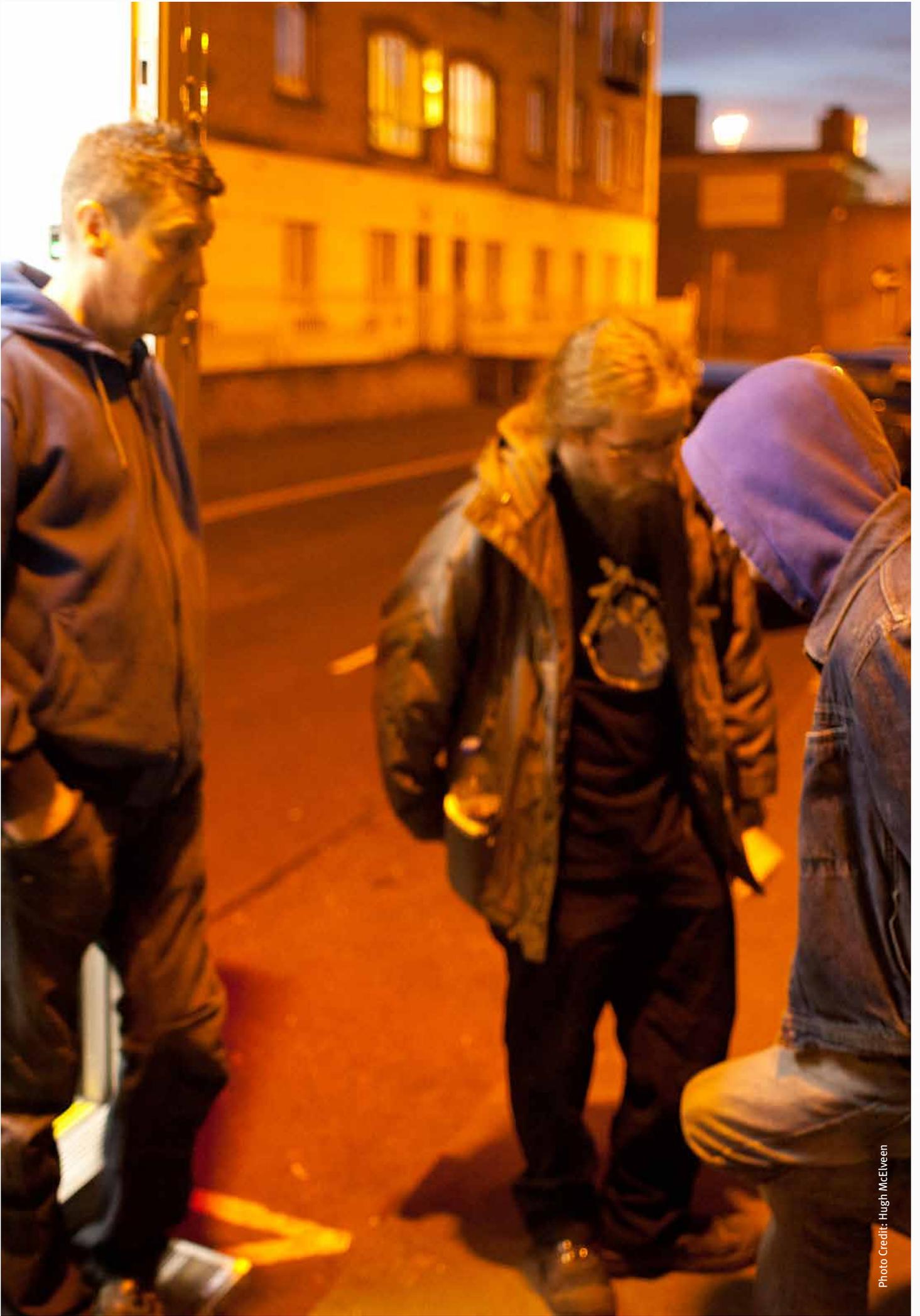


Photo Credit: Hugh McElveen

# 7. Access to and use of Health Services

## Highlights

Respondents were asked if they had a medical card and GP and if they used a range of primary and secondary care mainstream and specialised services for homeless people. Specialised services included Safetynet services in Dublin and hostel-based health services in Dublin and Limerick. Questions about use of services related to the previous 6 months. In addition, respondents were asked about satisfaction with services, barriers experienced and they were asked for their suggestions on how health services for homeless people could be improved.

- Greatly improved medical card coverage among homeless people.
- Registration with GPs and having a medical card was more prevalent in Limerick than Dublin.
- Over 80% had seen a GP or nurse in the previous 6 months.
- More than half had been seen in specialised primary care services for homeless. These were more commonly used by those with a diagnosis of mental or physical conditions and addiction problems.
- Reduction in overall proportion using psychiatric services but increase for some conditions.
- Increase in use of primary care services and general hospital services over time.
- Greater use of primary and psychiatric care in Limerick than in Dublin.
- Almost 60% reported having key workers and over 40% had care plans.
- Support within accommodation and having a key worker and care plan is more common in Limerick-based accommodation and in Supported Temporary Accommodation in Dublin.
- People with a key worker were more likely to have a medical card and use some services such as specialised health services for homeless people and psychiatric services.

## 7.1 Medical Card and GP Registration

At 77%, medical card coverage was over twice that of the general population among whom it is approximately 37% (Department of Health, 2012). It has also increased since previous studies which showed 55% coverage.

The improved coverage in 2013 is likely a response to the emphasis placed by homeless services on ensuring clients have medical cards. Registration with GPs is independent of medical card coverage so it is possible to have a GP but not be covered by a medical card to attend that GP. Registration with a GP was almost universal in Limerick and was higher in both Limerick and Dublin than medical card coverage. As indicated in Table 28 on the following page, there are many reasons why an individual may not have a medical card. However, most reasons can be interpreted as faults with the system or process of accessing and maintaining medical cards. These reasons are categorised as structural and account for 85% of those without cards who gave reasons for this (n=132). In a minority of cases (13%), respondents can be viewed as responsible themselves for not having a medical card. However, it could be argued that this would be irrelevant if medical card coverage for the homeless was automatic.

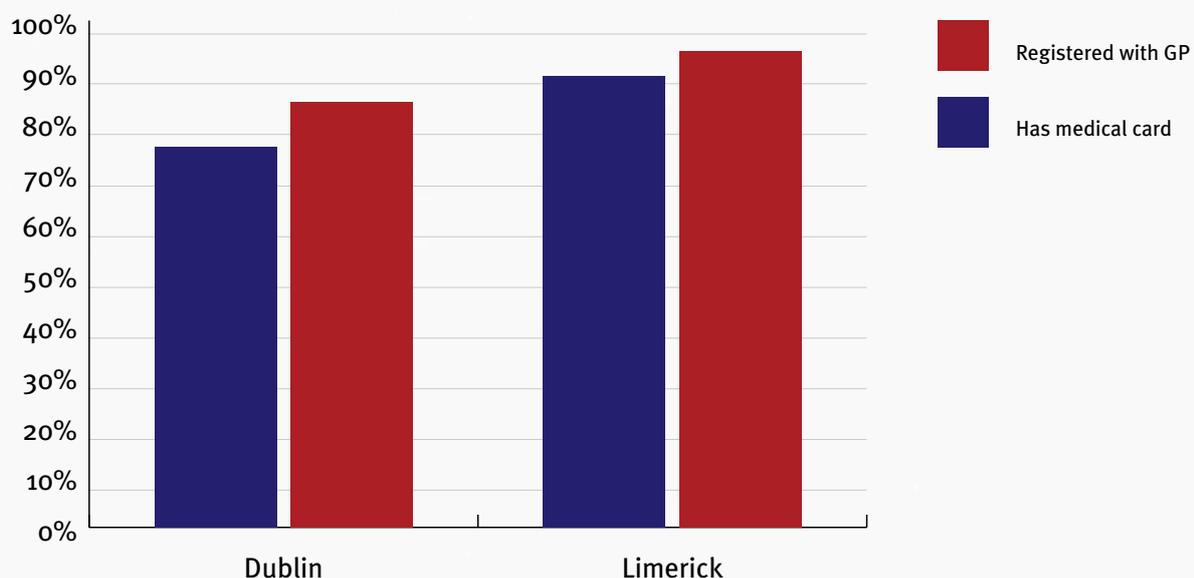
Respondents were registered with over 200 GPs with most GPs having no more than 2 or 3 of the sample among their patients. Three GPs in Dublin had a disproportion of the sample (between 17 and 39 patients who were homeless). In Limerick, no GP had more than 4 of the sample as patients, and most had one, suggesting that

homeless people are dispersed quite evenly among GPs there.

Homeless people with a mental health condition and/or a physical health condition were more likely to have a medical card than those without such a diagnosis. This is not surprising as having a medical card means one is better able to access health services and therefore may be more likely to have conditions diagnosed. Duration of homelessness was positively associated with having a medical card, however age was not. More people with a key worker (85%) compared to those without a key worker (65%) had medical cards. These findings suggest that homeless services and key workers in particular are associated with increased likelihood of medical card cover for homeless people.

There was no such increased likelihood for drug users on methadone suggesting that possession of a medical card may not be required or emphasised as important by drug services. Nevertheless, the high rate of medical card cover among the homeless population in general was reflected among those on methadone treatment. However, among those on methadone treatment, those receiving methadone from their GP were more likely to have a medical card compared to those attending clinics (93% vs 75%). While a medical card is not necessary to receive methadone treatment in a clinic, a medical card to access general medical care and other services including dental remains important.

**Figure 11: Medical card and GP registration**



**Table 28: Reasons no medical card**

		n=132	%
Structural	Applied, waiting response	38	29
	Expired but have not renewed	32	24
	Do not know how to get one	10	8
	Cannot apply as no stable address	9	7
	Not eligible	8	6
	Difficulties in filling form	7	5
	No GP	5	4
	Recent release from prison	3	2
	Other	3	2
Individual	Hasn't got around to applying for one	8	6
	Lost it	5	4
	Do need one / not applied	4	3

## 7.2 Use of Primary, Secondary and Specialised Services

Respondents were asked about the type of health care professionals they had seen and about their hospital inpatient and outpatient attendance in the previous 6 months. They were also asked if they had attended any of the specialised health services established for homeless people (Safetynet in Dublin and outreach services in Limerick).

### 7.2.1 Attending health professionals

Significantly more of the Limerick sample had seen their own GP in the previous 6 months compared with the Dublin sample (Table 29). Though more of the Limerick sample had also seen any GP or nurse in the past 6 months than the Dublin sample, the difference between the rates in the two samples is narrower. This is likely a result of the higher proportion in Dublin using specialised health services for homeless people (Table 30). Similarly, attending a psychiatrist or psychiatric nurse or a counsellor was more common among the Limerick sample. Having seen a social worker or dentist, however, was more common among the Dublin sample than the Limerick.

Women were more likely to have attended their GP in the past 6 months than men. People with a physical or a mental health condition were more likely to have seen their GP in the past 6 months than those without and more people with a key worker had seen their GP compared to those without (64% vs 54%).

People with mental or physical health conditions, women and those who had attempted suicide in the past were more likely to have seen a psychiatrist or a psychiatric nurse in the previous 6 months. People who had a key worker were slightly more likely to have accessed these psychiatric services than people without. Drug users were no more likely to attend psychiatric health professionals than non-drug users. Three quarters of those who had seen a psychiatrist had self-reported an addiction problem as well as a mental illness and 57% reported current drug use, suggesting that dual diagnosis was not a barrier to access. There was no increased likelihood for people receiving methadone in a clinic having seen one of these professionals over those receiving methadone from a GP.

**Table 29: Health professionals seen in the last six months**

		Dublin	Limerick	Total
Health professionals seen in the last 6 months	n	531	63	594
	Own GP	57.1%	81.0%	59.6%
	n	531	62	593
	Nurse	38.4%	40.3%	38.6%
		532	63	595
	Any GP or Nurse including special homeless services	81.5%	90.5%	82.7%
	n	525	61	586
	Social Worker	27.2%	19.7%	26.5%
	n	531	60	591
	Counsellor	30.1%	35.0%	30.6%
	n	531	61	592
	Chiropodist	5.1%	8.2%	5.4%
	n	531	61	592
	Dentist	27.9%	23.0%	27.4%
n	531	61	592	
Psychiatrist	17.9%	23.0%	18.4%	
n	529	61	590	
Psychiatric Nurse	10.4%	26.2%	12.0%	

### 7.2.2 Attending specialised services for homeless people

These services in Dublin are known as Safetynet services. In Limerick, outreach services by health professionals visiting hostels fall into this category. The services marked 'DUB' in the table below are Dublin based services not available to the Limerick sample. A significantly higher number of participants in Limerick saw a doctor or nurse in the hostel where they were staying compared to the Dublin sample. However, a significantly higher number of Dublin respondents reported seeing a doctor or a

nurse in another hostel. Overall, more of the Dublin sample appeared to use specialised health services for homeless people.

Specialised services were utilised more by people with mental or physical health conditions and drug users. People with key workers were almost twice as likely to use these services.

**Table 30: Use of specialised services for homeless people**

		Dublin	Limerick	Total
Doctor/ Nurse in specialised homeless services – last 6 months	n	526	63	589
	Brother Luke's (food hall) DUB	14.8%	NA	14.8%
	n	527	63	589
	MQI or other drop in centre DUB	22.2%	NA	19.9%
	n	527	62	589
	Hostel where you are staying	18.6%	29.0%	19.7%
	n	522	63	585
	In other hostel	13.2%	3.2%	12.1%
	n	524	63	587
	In detox/rehab/respite	10.7%	11.1%	10.7%
	n	523	61	584
	In Mobile Health Unit (Bus) DUB	18.7%	NA	16.7%
n	529	63	592	
Any specialised services –last 6 months		52.0%	38.1%	50.5%

### 7.2.3 Attending hospitals and health centre

Attendance rates in Accident and Emergency (A&E) were similar in both Dublin and Limerick (44%). Psychiatric hospital attendance was higher among the Limerick sample compared to the Dublin sample with psychiatric hospital outpatient attendance almost three times higher among the Limerick sample. Local health centres were rarely used by either sample but less so among the Limerick sample.

Those with a physical condition or a mental condition were more likely to have attended A&E in the past 6 months. More drug users also attended A&E in the past 6 months than non-drug users. People were more likely to have attended A&E if they had attended their GP or at least one of the specialised homeless health services in

the past 6 months. Having a key worker was not associated with attending A&E.

Eleven percent of the full sample had used psychiatric hospital services (inpatient or outpatient) in the past 6 months. There was higher usage in Limerick than in Dublin. People who had attended their own GP or one of the specialised services for homeless people were twice as likely to have used a psychiatric hospital service in the past 6 months. People who attended A&E were 3 times as likely to have attended a psychiatric hospital service. Almost 40% of people with schizophrenia or psychosis had attended a psychiatric hospital service in the past 6 months.

**Table 31: Hospital and health centre attendance**

		Dublin	Limerick	Total
Services attended in last 6 months	n	529	63	592
	A & E	44.2%	44.4%	44.3%
Hospital (outpatient)	n	527	63	590
		28.1%	27.0%	28.0%
Hospital (inpatient)	n	527	63	590
		23.7%	25.4%	23.9%
Local Health Centre	n	524	63	587
		14.3%	4.8%	13.3%
Psychiatric Hospital (inpatient)	n	528	62	590
		5.7%	8.1%	5.9%
Psychiatric Hospital (outpatient)	n	528	63	591
		6.4%	17.5%	7.6%

### 7.3 Changes in Health Service Use Over Time

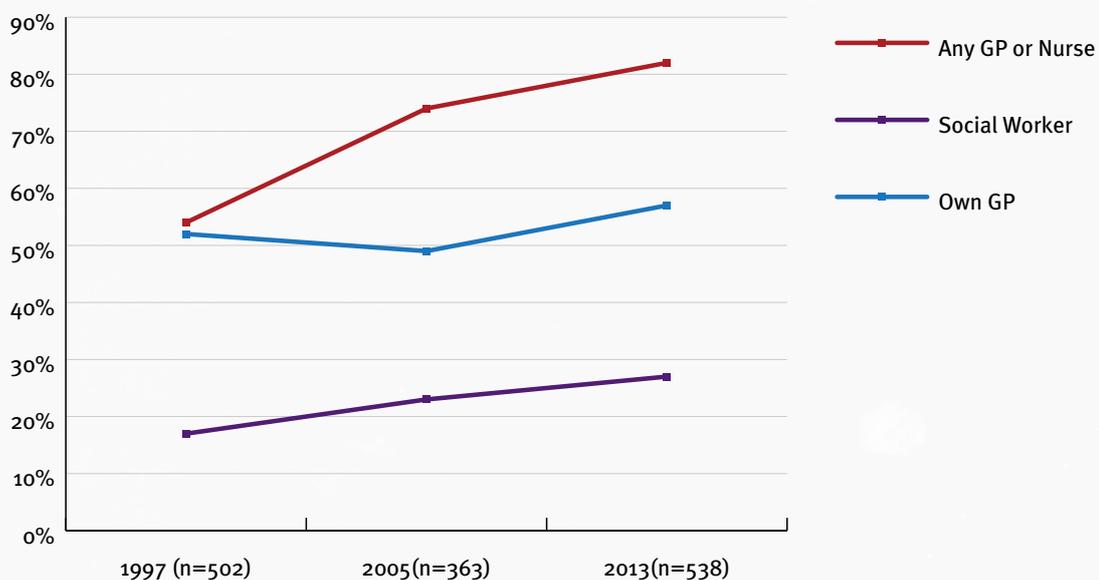
In 1997, just over half the homeless in Dublin had seen their own GP in the past 6 months. This was slightly lower in 2005 and rose in 2013 to 57% (Figure 12). The proportion that accessed a GP or nurse either in mainstream or specialised primary care services in the past 6 months increased significantly to 82% in 2013. Proportions accessing social work also rose but not as significantly. Attending a counsellor was not measured in 1997; however this was slightly higher in the sample in 2013 at 30% than in the sample in 2005 at 27%.

Only people with anxiety and depression were asked about visits to psychiatric services in 1997, therefore comparison only for this subgroup for the three homeless surveys is possible. Over time it appears that consultations among the subgroup with anxiety or depression with psychiatric nurses declined from 28% in 1997 to 20% in 2005 to 15% in 2013 (Figure 13). Among this subgroup, the rate of consultations with a psychiatrist increased from 1997 to 2005 and reduced in the 2013 survey. Asking this question of the full sample in the latter two surveys also reveals a reduction. However, for people reporting a diagnosis of schizophrenia or psychosis, there is an increase in attendance with a psychiatrist and psychiatric nurse from 2005 to 2013. These findings may suggest a more precise targeting of psychiatric services toward certain psychiatric conditions such as schizophrenia and psychosis and away from conditions such as

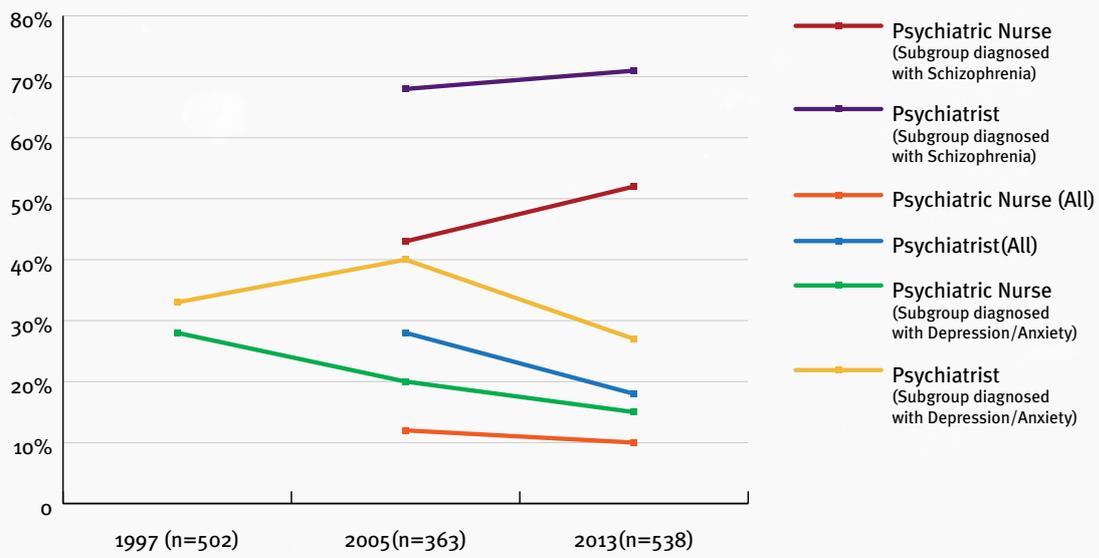
depression and anxiety which may be considered more appropriately treated by primary care physicians. Though the health section of this report shows most people who received a diagnosis of anxiety or depression also received some form of treatment, it also shows that these individuals have a higher rate of suicidality. It is therefore suggested that in the context of homelessness, diagnosis of a mental health problem represents a marker of risk even though treatment may have been received by many.

The increased report of attendance with psychiatrists in 2005 may have been influenced by the increase in numbers accessing methadone clinics (with psychiatric services available) established in response to what was referred to as the 'opiate epidemic' in the nineties (Butler, 2002). Another structural influence may have been the fact that St. Brendan's mental health programme for homeless had not yet decommissioned services completely. Given the serious burden of poor mental health indicated by the levels of depression and anxiety as well as suicidality outlined previously, there is a need for a clear articulation of what constitutes appropriate mental health supports and services, including suicide prevention and voluntary sector services, for this cohort. The structural divide between mental health services and addiction services requires addressing so that care is coherent and seamless from the users' perspective.

**Figure 12: Primary care usage in previous 6 months**



**Figure 13: Attended psychiatrist or psychiatric nurse in previous 6 months**

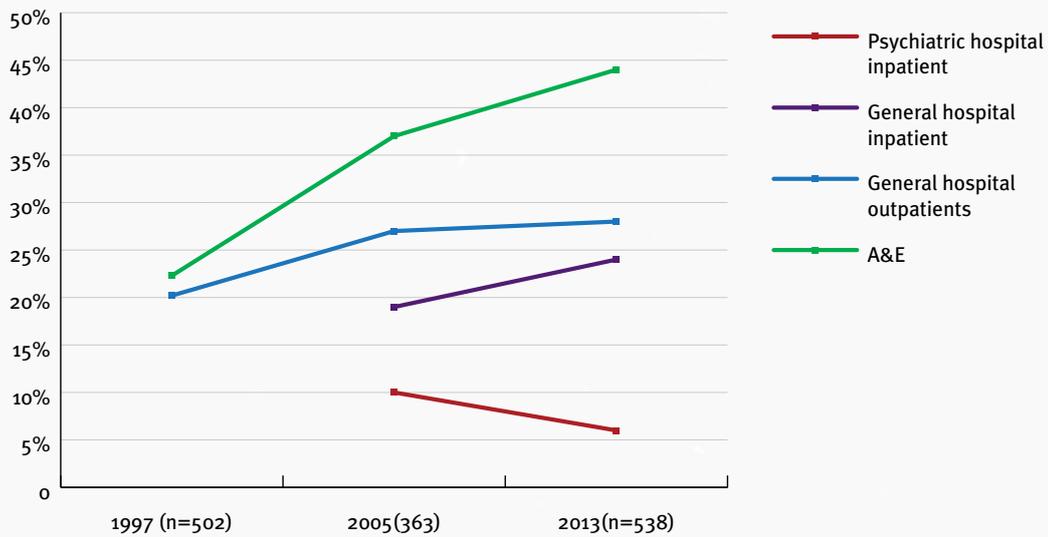


### 7.3.1 Changes in hospital attendances over time

Figure 14 shows A&E attendance among the homeless population has increased over time suggesting that the increased access to primary care services is not preventing use of acute secondary care services. High A&E attendances may also be influenced by the increase in drug use over time. Inpatient attendances have increased slightly over time from 19% in 2005 to 24% in 2013.

Outpatient attendances remain relatively static since the 2005 survey but have increased on the 1997 rate. Psychiatric inpatient admissions among this cohort had reduced since the 2005 survey, perhaps reflecting the policy change encouraging reorientation of psychiatric services away from inpatient care towards care in the community (DOHC, 2006)

**Figure 14: Hospital attendance in previous 6 months**



## 7.4 Immunisation

Hepatitis B virus (HBV) is an important cause of serious liver disease including acute and chronic hepatitis, cirrhosis and primary hepatocellular carcinoma. People with chronic HBV infection can transmit the infection for many years. The prevalence of HBV in the general population in Ireland is low (less than 1%) and most cases fall into defined risk groups such as injecting drug users, prisoners and homeless people.

As such, vaccination among the homeless population is important. Overall, over 40% reported full vaccination and this was higher (over 60%) among injecting drug users. Vaccination among the Dublin sample was more common than among the Limerick sample. In Dublin, vaccination against HBV was slightly higher than in the 2005 survey (38%) but remained similar among injecting drug users (61%).

Homeless people also fall into the category of people at risk of Hepatitis A which is transmitted via the faecal-oral route and is associated with poor hygiene and sanitation. Almost 40% reported vaccination against Hepatitis A. Influenza vaccination was reported by 29% of the full sample which is higher than that reported in 2005 (22%). Homeless people were more likely to have been given a flu vaccination if they had visited their GP or attended a specialised homeless health service in the past 6 months.

Current or past injecting drug users were more likely to have received Hepatitis A or B vaccinations. Seventy one percent of injecting drug users had received either one. People in receipt of methadone from clinics were no more likely than those attending GPs to have accessed vaccinations in the previous 6 months.

**Table 32: Vaccinations received**

		Dublin	Limerick	Total
Vaccinations	n	510	63	573
	Flu (in the last year)	28.0%	33.3%	28.6%
Hepatitis A	n	497	63	560
		39.2%	33.3%	38.6%
Hepatitis B	n	493	62	555
		44.4%	25.8%	42.3%

## 7.5 Satisfaction with Health Services

The majority of respondents rated services as OK, good or very good with 43% giving positive ratings (good or very good). Satisfaction among the Limerick sample was

higher compared to Dublin. Satisfaction with services has improved since the last survey when 37% gave negative ratings in Dublin compared to 24% in 2013.

**Table 33: Satisfaction with health services**

		Dublin	Limerick	Total
Health services for homeless people	n	508	63	571
	Very good	12.6%	36.5%	15.2%
	Good	27.8%	31.7%	28.2%
	Ok	35.0%	22.2%	33.6%
	Bad	11.6%	3.2%	10.7%
	Very bad	13.0%	6.3%	12.3%

## 7.6 Barriers Experienced

Thirty eight percent (n=219) of homeless people said they experienced barriers (problems) trying to access health care. People mentioned more than one barrier totalling 287 responses. Barriers were grouped into categories presented below. Twice as many of the Dublin sample reported experiencing barriers than the Limerick sample (40% vs 19%).

Those giving ‘other’ uncategorised reasons (n=27) gave a range of reasons including lack of knowledge about services, missing appointments, difficulties getting entitlements such as disability allowance and

being barred from some services. Some people reported experiencing discrimination.

*“They look at me as if I’m a junkie”*

*“I’m treated differently because I’m homeless”*

Among those who suggested they could not get the treatment they needed, some complained about difficulty in getting psychiatric care and a few said accessing dental care or a benzodiazepine detox was difficult.

**Table 34: Barriers to accessing services**

Barriers mentioned	n=287	%
Previous negative experiences	79	28
Service(s) not open when needed	42	15
No medical card	41	14
Too expensive/cost	36	13
Other	27	9
Long waiting	23	8
Can’t get required treatment	13	5
Other things more important	12	4
Difficulty getting a GP	10	3
Not legally resident	4	1

## 7.7 Support and Assistance at Accommodation Setting

Two thirds of the total sample received assistance in accessing health services through their accommodation. This kind of support was reported more frequently among the Limerick sample than the Dublin sample. Similarly, more of the Limerick sample reported having a key worker and a care plan.

In Dublin, people staying in Supported Temporary Accommodation (STA) were more likely to have a key worker

(82%) than people in Private Emergency Accommodation (PEA) and other types of accommodation<sup>6</sup> (25%). Similarly more people in STAs in Dublin reported that there was support to access health services, available to them in their accommodation (84%), compared to those in PEA and other accommodation (39%). In Limerick those reporting having a key worker (81%) and support to access health services in their accommodation (94%) were similar to those in STA accommodation in Dublin. Having a key worker was associated with having a care plan.

**Table 35: Type of assistance received**

	Dublin	Limerick	Total
n	508	62	570
Assistance in accommodation to access services	63.4%	93.5%	66.7%
Has key worker	56.1%	80.6%	58.8%
Has care plan	39.6%	62.9%	42.1%



Photo Credit: Hugh McElveen

<sup>6</sup> Other accommodation refers in the sample to private charity accommodation i.e. Regina Coeli & Morning Star

## 7.8 Suggested Improvements to Health Services for Homeless People

Respondents were asked to suggest improvements for health services for homeless. This was an open question so answers were analysed qualitatively rather than quantitatively. Responses were categorised and grouped based on content to identify themes. Most respondents provided a comment. Many reported a positive experience of the health services available to them, asserting that no improvements were needed or that all their needs were currently being met by the services available to them.

*“I think they’re good - Think they’re doing the best they can”*

*“I’m happy with services available to homeless people”*

### 7.8.1 Health service improvement

Those who felt improvements were warranted said that more health services were required rather than having an issue with those currently available. Some respondents felt that there was a particular need for services at homeless accommodations or for more regular visits by health professionals to their accommodation. Some felt there should be a greater range of specialised health services available on site, such as dentists and counselling services.

*“Health services need to make constant visits to the homeless to see their problems and needs”*

A few suggested that the mobile health unit or similar should be more available to homeless people as *“individuals may be unable to get to doctors’ surgeries or may not have access to appropriate information.”* Another idea suggested was the creation of an emergency health service specifically to cater for the needs of homeless people.

The length of waiting was an issue for people not just in the A&E but to see professionals in general i.e. key workers, GPs and detox and rehabilitation.

### 7.8.2 User-friendly accessible information

There were complaints about a lack of adequate information on services available.

*“More access to information on health services. Internet access in hostels to get this information should be standard in all hostels”*

Ideas to combat this were the establishment of groups focused on health and the establishment of a one stop shop which would be particularly useful for those entering homelessness for the first time.

### 7.8.3 Non-discriminating services

Some felt that they were treated negatively by some services due to their homeless status. People wanted to be treated equally and recognized as individuals. They wanted to be heard and not judged based on drug use or homeless status.

*“To be noticed. To be asked. Not to be invisible, just left there. It’s hard enough being homeless without being treated like you are on the bottom.”*

*“Prejudice around addiction or homelessness should be stopped.”*

*“I feel discriminated against by doctors and welfare services”*

However, the discrimination homeless people felt was primarily from mainstream services and not from homeless specific services.

### 7.8.4 Housing

Though participants were asked specifically about health service improvement, housing was identified as a priority and the key to improving health.

*“Get homeless people off the streets so they can get better health services”*

*“If the housing facilities were better and so many not boarded up then less people would be homeless and their health would be better”*

The two-way relationship between housing and health was also recognised.

*“If health was better taken care of they could move on to private accommodation sooner”*

Landlords were blamed for the lack of access to accommodation in the rental market due to their refusal to rent to people using 'rent allowance'. This mitigated against people trying to get out of homelessness.

*"Landlords should be taking rent allowance"*

Other respondents said there should be more housing available in general and from the City Council, rather than continuous temporary hostel accommodation.

### **7.8.5 Better accommodation, access and activities.**

The link between physical environment and health was alluded to with many respondents highlighting the need to improve the current accommodation. People felt hostels should have longer opening hours together with more activities available during the day to keep people off the streets.

Cleaner hostels, single rooms and the segregation of drug and non-drug users were frequently referred to. Twenty-four hour access and activities during the day were seen as a priority and could impact health positively.

*"Have somewhere for people so they are not on the streets all day. This will improve health."*

*"Activities programme for the weekend, services at weekends and activities for the kids"*

Emphasis was placed on more permanency and a longer stay in hostels rather than being moved around so frequently.

*"Help to find permanent accommodation or at least stay in current accommodation and not get moved around."*

*"I keep getting sent to loads of different places"*

## **7.9 Summary**

Access to and use of health services appear to have improved over time, with increased proportions of homeless people in possession of medical cards entitling them to a range of free services. However, almost one quarter still report not having this entitlement and cite a range of structural barriers making this difficult. Given the evidenced health need of this cohort access to health care should be automatic and administrative barriers eliminated.

Use of mainstream primary care services appears to be better in Limerick than in Dublin as does use of psychiatric services. This is in the context of need being as great or greater in Dublin. It is clear that the specialised primary care services particularly in Dublin are critical to ensuring health care access, given that use of mainstream GPs overtime remains not much higher than 1997. This suggests that mainstream services cannot adequately cater for the needs of such a large population of homeless in Dublin with such high and complex needs. Indeed, the increasing rates using A&E is a reflection of the extent of such need.

The reduction in the use of psychiatric services in Dublin may reflect more precise targeting of these services but may also represent barriers to appropriate access to care or increasing numbers entering homelessness without corresponding increasing resources. This requires further exploration.

Clearly, the key working and care plan model in tandem with supported accommodation has been effective with those accessing these supports having increased access to health care and services.

Homeless people themselves make pertinent suggestions to improve services, including making them user friendly, easily accessible and importantly non-discriminatory. While they are appreciative of the services being provided, they see that ultimately, exiting homelessness will have the most positive effect on their health.

# 8. Discussion of Findings

## 8.1 Summary

It is unsurprising that this study, like many others, has found that there are high rates of a range of illnesses among the homeless. There are concerning findings regarding addiction and alarming rates of depression, suicidal ideation and attempted suicide. There is evidence of increased rates of diagnosed physical and mental conditions over time that may be explained by increased access to health services and therefore to a diagnosis. Increased access to health care entitlement through possession of a Medical Card had increased in Dublin and was high in Limerick.

Changing patterns of drug use show poly drug use as the norm with increased cannabis smoking, abuse of benzodiazepines and reduced heroin use among the younger cohort. While not everyone with an opiate addiction was on methadone there was good coverage of methadone treatment. The amount of substance abuse (both legally and illegally obtained) among those on methadone treatment raises concerns. Dual experience of a mental health problem and an addiction was commonplace rather than the exception.

In terms of services use, the increase in access to and use of primary care services is accompanied by an increase in use of secondary care services i.e. accident and emergency and acute hospital admissions. Perhaps counter-intuitively, given the level of mental health diagnosis and suicidality, psychiatric service utilisation in Dublin appears to have decreased for those with anxiety and depression.

Staying in STA accommodation and having a key worker was associated with increased use of health services and with case management through the implementation of care plans.

Differences between Limerick and Dublin suggest that access to health services and entitlements in Limerick appear to be better than in Dublin, which is likely a result of the far more manageable cohort of homeless people. While the lower rate of drug related morbidities in Limerick may be a consequence of the lower rate of heroin addiction it could also suggest that these conditions were not routinely looked for.

## 8.2 Study Strengths and Weaknesses

Given the recognised difficulty engaging homeless populations for research the response rate achieved in this study is reasonable (64%). However, because the participants were ultimately self-selecting, their responses may be different to non-responders. The response rate in Limerick was lower than in Dublin. This may be a result of limited resources which did not allow for a team leader on site in Limerick.

The sample selected was restricted to the Dublin city area (except for one accommodation housing foreign nationals) and Limerick city, so is not representative of the full homeless populations outside these catchments. We also purposively sought out rough sleepers. However, the method used for accessing this group via the medical outreach unit, can influence responses about service utilisation. A reduced set of questions was developed for rough sleepers as testing showed the 20 minute interview was too long.

Comparisons across time use the full samples from 1997, 2005 and 2013. The 2005 sample included homeless people in hostels, transitional accommodation and B&B accommodation on the north side of the city only. Though it is unlikely that these differ from those on the south side this is not guaranteed. To account for this potential bias, we compared a number of key indicators to see if

there was a north / south difference but there was no evidence of this.

Structural issues relating to how accommodation is provided for the different categories of homeless and where it is located dictates which homeless people will be found in our sample. Therefore, homeless people not allocated to this type of accommodation will not appear in our sample. This is exemplified by the lower proportion of accommodations that are more likely to house families with children (PEAs) within our Dublin sample than outside our catchment area. The organisation of these services has changed over time and therefore may impact on comparisons.

### 8.3 Demographics

The demographic profile (in terms of age and sex) is similar to the census data for the full homeless population in Ireland (CSO, 2012). This age/ sex structure has not changed since the 2005 survey but appears younger and less male dominant than the 1997 survey. The sample was younger than the general housed population and predominantly male and single (CSO, 2012). The sample was similar to the general housed population in terms of ethnicity and religion (CSO, 2012). As found in other studies the vast majority were out of work (Holmqvist, 2009; Zlotnick & Zerger, 2009; Chard, 2009). The proportion reporting that they were cohabiting had increased since 1997 reflecting the changes in social norms over time and there was a similar proportion separated and a much lower proportion divorced than in the general population (CSO, 2012).

The single male-dominant, unemployed population is also reflective of homeless populations in other countries (U.S. Department of Housing and Urban Development [HUD], 2011; Caton et al., 2005; Gaetz et al., 2013). This reflects the absence of the social support of family and friends that is an important determinant of homelessness (Ferguson, 2009; Martin & Sharpe, 2006; Heerde et al., 2012). Though the self-reported reasons for homelessness cannot be accurately compared over time it would appear that family problems, drugs and alcohol addiction are reported by most in all surveys (Ferguson, 2009; Martin & Sharpe, 2006; Heerde et al., 2012; Wu et al., 2010). Homelessness was more often reported as long-term (over 6 months) by the Dublin compared to the Limerick sample with the majority of the full sample stating that

they had also been homeless on a previous occasion. There were fewer homeless for more than a year compared to 2005, perhaps indicating success of strategies aimed at reducing long-term homeless (Department of the Environment, Heritage & Local Government [DEHLG], 2008; The Homeless Agency, 2009). A reduced proportion of long-term homeless could also be the corollary of more recent entrants to homelessness.

There were fewer children among the 2013 sample than in 2005. While this may reflect an actual decrease among the full homeless population as a result of strategies aimed at preventing families becoming homeless, it may also be an underestimate of families in our sample. Nevertheless, it is probable that the numbers of children in homelessness increased significantly after our survey when families had to be accommodated in hotels because capacity in accommodations designated for families was reached (RTE News, 2014). There appears to have been a significant time lag between the Irish economic crash 2008/9 and the significant increase of families entering the homeless sector which began towards the end of 2013 (DRHE, 2014). One explanation for this is that families were accommodated in the rental market through the provision of rent allowance by the Department of Social Protection until rents became unaffordable and stock diminished. This led to a new crisis for families. Towards the end of 2013 and beginning of 2014, these families entered homelessness but were accommodated in hotels rather than in the traditional accommodations surveyed as part of this study.

The over-representation of people who were in state care as children in our sample is worrying though it is replicated internationally (Rosenthal et al., 2006; Ferguson, 2009; Whitbeck et al., 2004) and suggests the need for increased social supports to prevent homelessness among those in care.

### 8.4 Addiction

The growing numbers of homeless people with drug and alcohol addiction is echoed in the literature (Fazel et al., 2008; Levitt et al., 2009; Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). This suggests there may be a more difficult exit path for these people (Kertesz et al., 2009; Palepu et al., 2010; Greenberg & Rosenheck, 2010). Our study finds a higher rate of active illicit drug use compared to previous studies. The

replacement of alcohol by drugs as the main addiction is seen through the literature (Condon et al., 2001; Lebrun-Harris et al., 2013; Levitt et al., 2009; Hwang et al., 2011). The changing pattern over time also sees poly drug use as the default pattern of drug use with opiates being less used by the younger cohort who show increased use of minor tranquillizers and cannabis (Meade et al., 2001; National Addiction Centre, 2002; Lempens et al., 2003). Nevertheless, there is still a high rate of heroin addiction among the sample and good coverage of methadone treatment particularly in Dublin. However, there appears to be a need to increase coverage for rough sleepers given the lower coverage rates.

Many of those on methadone treatment reported abusing a range of other substances with the majority reporting also using illicit drugs including heroin. Homelessness increases illicit drug use and is also a barrier to exiting homelessness (Kertesz et al., 2009; Palepu et al., 2010; Greenberg & Rosenheck, 2010). It would make sense for the services to target and treat poly drug use as the default rather than emphasising opiate substitution. Given the association between homelessness and substance abuse, it would also make sense for stable accommodation to be a treatment goal for all addiction services engaged with homeless people.

There is also an increase in rates of dangerous drinking, particularly among women, whose dangerous alcohol consumption is now on a par with men. Increased drinking among homeless people has been shown to have very poor health outcomes (Grinman et al., 2010; Nyamathi et al., 2010). Though smoking among the homeless was almost universal, smoking in the context of other risk taking behaviours tends to be ignored by services (Okuyemi et al., 2006; Butler et al., 2002; Arnsten et al., 2004). This needs to be addressed.

Access to non-medical addiction services appeared to be good. Most had used drug services (counselling, needle exchange, inpatient detox, rehab, aftercare and stabilization) in the previous 12 months. While there was an increase in methadone treatment coverage in Dublin since the last survey, the structure of provision had not changed with the majority of homeless people attending centralised centres. Providing methadone to homeless people through specialised health services in homeless hostels has been successful on a pilot basis (O'Reilly &

Murphy, 2011). The interplay between physical health, mental health and addiction undoubtedly frustrates attempts to exit homelessness (Hodgetts et al., 2007; Kertesz et al., 2009; Palepu et al., 2010). Service provision should therefore be coherent from the users' perspective rather than separate and disjointed.

## 8.5 Health

This study, like other studies, found that the homeless had higher rates of a range of illnesses compared to the general population (Bagget et al., 2010; Smith et al., 2001; Haddad et al., 2005). Almost the entire sample had either a diagnosed mental or physical health problem with the majority also receiving treatment for ill health. Because the questions on illness reflected illness diagnosed by a doctor, the increase found over time may be due to increased access rather than actual increase in morbidity. This would explain the little change in poor self-reported health status which itself matches well with health outcomes and service use (Bond et al., 2006; Manor et al., 2001). The increase in those taking prescription medications over time also mirrors the increasing morbidity.

Mental health issues were very common and are commonly associated with addiction problems. This is also reflected in the literature (Bharel et al., 2013; Doupe et al., 2012; LaCalle & Rabin, 2010). Rates of self-harm, suicidal ideation and attempted suicide are all elevated among this population as is seen in the literature (Eynan et al., 2002; Prigerson et al., 2003). The stark finding that more than a third of the study sample has attempted suicide requires attention.

Added to this are the factors of addiction and the length of time spent homeless, both of which are associated with attempted suicide. Longer length of time spent homeless is likely an aggravating factor for all these health conditions. It is likely that relationships between these issues are inter-linked with a need for programmes and interventions to target multiple risk-factors among the homeless and among those at-risk of homelessness. A specific suicide prevention strategy among this population is warranted. In general, the physical health of the Dublin sample was worse than that of the Limerick sample, however mental illness was highly prevalent in both cities.

Drug and alcohol addiction and mental health issues present as the most pressing of health concerns and are associated with secondary health problems also found elevated among this population, such as liver disease, dental problems and Hepatitis C. While report of Hepatitis C has reduced since 2005 it was still far higher than among the general population (Hewett et al., 2013; Hewett et al., 2012; Buchanan et al., 2006). Limerick showed no Hepatitis C, however this may reflect limited or no screening rather than absence of the condition.

## 8.6 Health Services

Health service usage has increased over time. Access has improved with more homeless people having medical cards and being registered with GPs. Though primary care access has improved this has not reduced use of secondary care but rather appears to be associated with an increased use of general hospital services. Given the burden of disease in this population this may reflect appropriate referral. Nevertheless, in line with experience in other countries there was very high use of A&E (Bharel et al., 2013; Doupe et al., 2012; LaCalle & Rabin, 2010).

Those more likely to attend A&E departments had also attended other health services recently (psychiatric hospital, GP, specialised health services for homeless and addiction services). This means that people end up

at A&E though they are known to health services and possibly a number of health related services. A strengthened liaison system between these services and A&E may enable monitoring of care for homeless people referred to A&E and follow-up care (Hewett et al., 2013; Hewett et al., 2012). The introduction of an intermediate care centre (O'Carroll et al., 2006) as exists in many other countries, would reduce the increased burden on A&E departments and improve appropriate care for homeless people unable or unwilling to wait at busy A&E departments (Kertesz et al., 2004; Kertesz et al., 2009; Buchanan et al., 2006).

The general increase in use of primary and secondary general medical services is contrasted by the reduction in use of psychiatric services including hospital admission. While it is possible that many milder mental health problems are increasingly and appropriately being managed by primary care services, the burden of mental health, dual diagnosis and suicidality, found in the context of such a reduction is noteworthy. The structural changes to the mental health system that reoriented psychiatric services towards community services and away from institutional care and reduced overall psychiatric inpatient beds, may account for the fewer inpatient stays (DOHC, 2006). However, this can be viewed positively only if homeless people with serious mental health problems



Photo Credit: Hugh McElveen

are receiving appropriate care in safe and stable settings as an alternative. The impact of this structural change on care for homeless people therefore requires evaluation. Literature suggests a reciprocal relationship between homelessness and psychopathology with mental health morbidity preceding homelessness as well as being aggravated by it (Gorde et al., 2004; Sullivan et al., 2000; Caslyn et al., 2002; Hodgson et al., 2013).

Our study supports previous recommendations for affordable housing options to prevent the mentally ill becoming homeless and for a crisis house for homeless mentally ill patients (DOHC, 2006). The Housing First model has also been shown to positively impact the lives of individuals with mental health problems (Tsemberis, 2010).

The homeless population is more vulnerable to blood borne viruses and seasonal influenza (Beijer et al., 2011) and while there were higher vaccination rates than the general population, efforts should be made to increase these further. A minority of people with a diagnosis of Hepatitis C said they were neither offered nor assessed for treatment.

Health service use and access appears to be greater in Limerick than in Dublin with increased use of own GP

compared with Dublin. Arguably therefore, specialised services for the homeless play a bigger role in increasing access to primary care in Dublin than in Limerick. This may be simply an effect of smaller more manageable numbers of homeless in Limerick. Use of psychiatric services in Limerick also was higher than in Dublin.

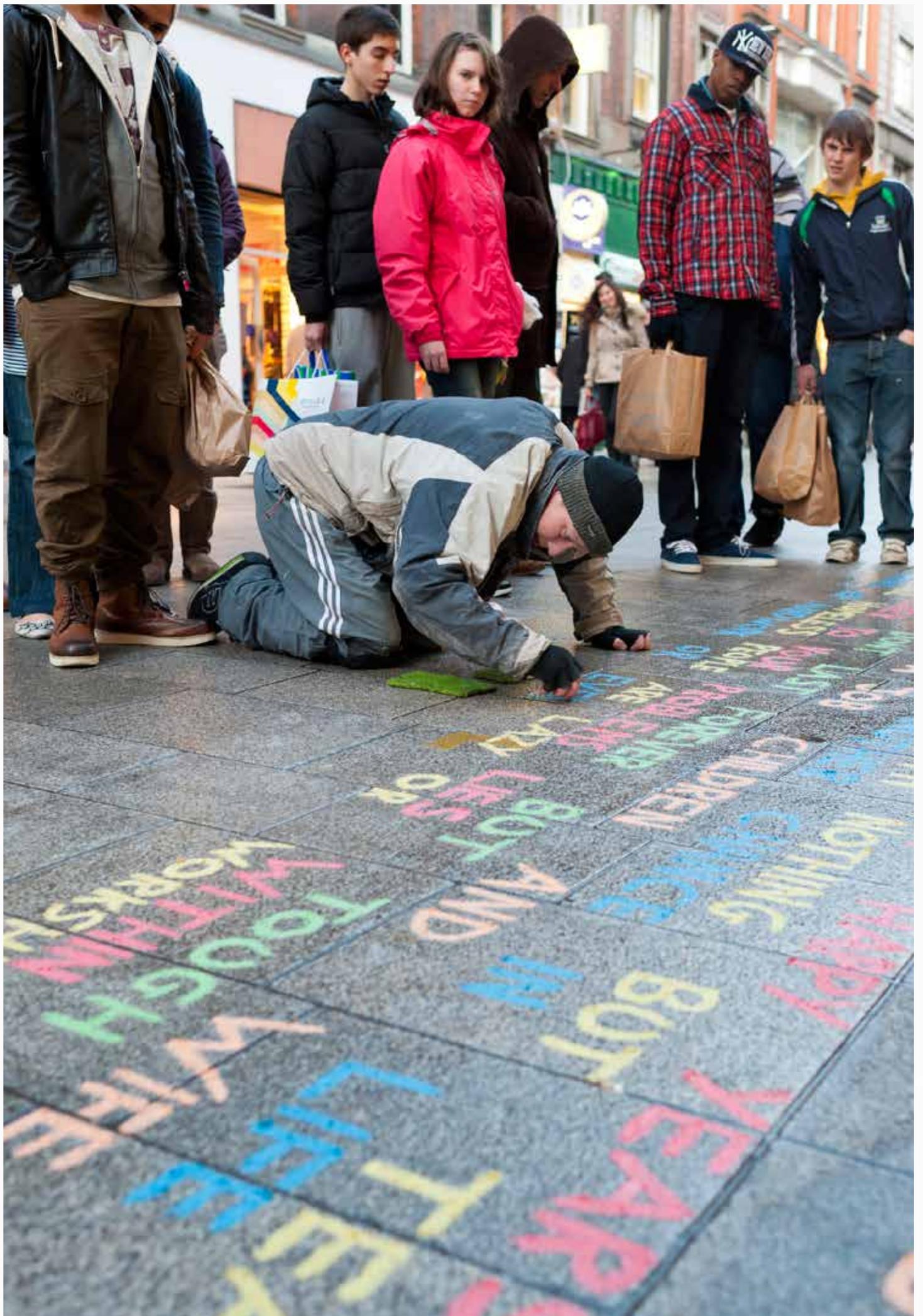
### 8.7 Access

People staying in Supported Temporary Accommodation reported receiving support to access health services and having a key worker. Having a key worker was positively associated with better health service access e.g. using specialised health services and attending psychiatric services, as well as having a care plan.

Over one third identified barriers including previous negative experience, inaccessible opening times, no medical card, expense and waiting. The most significant barrier in 1997 relating to poor access was not having a medical card. This barrier appears to have been systematically removed for most. Homeless people in our survey recommend user-friendly accessible information about services, non-discrimination, and better homeless accommodation with 24 hour access and activities. Fundamentally they recommend housing.



Photo Credit: Hugh McElveen



# 9. Conclusions

The study indicates that homeless populations have clear health needs with a greater likelihood of experiencing a number of forms of morbidity. O'Toole's theory of negative selection bias, that those with poor health are less likely to exit homelessness, appears relevant here (O'Toole et al., 2002; O'Carroll & O'Reilly, 2008). The three surveys were conducted in very different economic climates yet show a very high and increasing burden of poor health. While negative selection may be at play in preventing exit from homelessness it may also increase likelihood of homelessness in the first place.

As evidenced through the literature (Condon et al., 2001; Sibthorpe et al., 1995; Smith et al., 2001), homelessness is an unhealthy state with homeless people suffering disproportionate levels of illness and addiction. Drug and alcohol addiction and mental health issues present as the most pressing of health concerns and are associated with secondary health problems also found elevated among this population, such as liver disease, dental problems and Hepatitis C. Poly drug use and dual diagnosis appear as the norm rather than the exception. This presents challenges for addiction and mental health services that have evolved separately over time. The development of the addiction services requires reorientation towards decentralised services that target poly

drug use and are delivered to people closer to where they are, in a comprehensive manner. A coherent strategy for health care for homeless people with exiting homelessness as a treatment aim needs to be developed in collaboration with all the relevant sectors and specialties so that it is coherent and relevant from the users' perspective.

Overall, the health needs of the homeless are great and though much has been done already to improve access and care, much more can be done, particularly in the area of mental health and addiction. Ultimately though, a move away from the homeless situation will improve health and wellbeing.

# 10. Recommendations

## Improved Service Coherency

- A national strategy for health care provision for homeless people should be developed. Though strategic actions are contained in various planning documents (Department of the Environment, Community and Local Government [DECLG], 2014; HSE, 2015; HSE, 2014), it may be useful to articulate strategy and care provision in one accessible and user friendly document for this very vulnerable group with high health care need.
- In Dublin, a special homeless health committee should be established with representation from key stakeholders including specialised homeless primary care services, homeless mental health services, homeless addiction services, A&E departments, inpatient psychiatry, and accommodation services (e.g. Housing First Team and the DRHE). The purpose of such a committee would be to establish fluid referral pathways and points of communication to improve access to treatment care and housing for the most chronically unwell homeless.
- The appointment of an A&E liaison person for homeless people should be considered. This person could be a point of contact for, and provide feedback to, a central point / coordinator nominated by the above committee in order to facilitate continuity of care particularly for homeless people in crisis.
- There is a need to orient services towards the multiple needs of the service user rather than fitting the service user into service-centred systems. This means providing comprehensive services at the point of contact for co-occurring conditions such as addiction and mental health issues. Multidisciplinary team services for dual diagnosis should be easily accessible for homeless people with addiction and mental health problems.
- A full and comprehensive system of health care which aims for 'exiting homelessness' as the treatment goal should be designed. This would include multidisciplinary specialised primary care services with user friendly referral pathways to and from mainstream primary care, secondary care and importantly psychiatric and mental health care. Consideration should be given to the development of an intermediate care centre (or respite) for people not requiring hospital but too unwell for homeless accommodation. This system of health care would rely on the very effective care and case management implemented by key workers and work closely with the homeless accommodation services, in particular the Housing First team. This approach would increase quality of care and reduce the current over-reliance on secondary care seen in this study. More importantly it would remove barriers to exiting homelessness related to mental / physical health and addiction.
- Regular monitoring should be conducted to ensure an integrated approach is maintained across the services for homeless people and between primary and secondary services, as well between specialised and mainstream services.

## Improved Health Care

- On site accessible health services should be recognised as the most appropriate for this population of high health need. Expansion of specialised primary care services should be considered to include a full primary care team for homeless people with professional disciplines reflecting the needs of the particular population i.e. mental health social workers, occupational therapists, nurses, GPs, support workers and psychotherapists.
- Access to Hepatitis C testing and treatment needs to be improved for this population to improve rates of people with Hepatitis C going for treatment in Dublin. Treatment needs to be made available in Limerick.
- While reduction in psychiatric inpatient admissions reflects national strategic aims, the specific impact on homeless people requires monitoring to ensure that this does not present as a barrier to appropriate admission by homeless people.
- As a matter of urgency a coherent and specific stepwise approach to presentations by homeless people in crisis, in line with national suicide prevention guidelines should be established and rolled out within the homeless sector. A crisis house for homeless people as recommended in 'A Vision for Change' needs to be established (DOHC, 2006).
- Appropriate mental health interventions and strategies for homeless people with mental health issues or at risk of suicidal behaviour need to be clearly articulated and targeted to those in need.
- Professional cadres equipped with specific skill sets to meet clients' needs such as mental health support workers and social workers are needed on site in homeless accommodations in numbers commensurate with the very high mental health need evidenced in this study. Mental health training and guidance for workers in the homeless sector, on appropriate supports for clients, is needed.

## Health Promotion

- There is a need for smoking cessation interventions among the homeless population. The extremely high level of smoking will mean that even low success rates may convert into high numbers of people stopping smoking. This strategy may have further positive consequences on physical morbidity and confidence to tackle other addictions.
- Alcohol reduction interventions are required to tackle the high rate of alcohol consumption, particularly the increase in dangerous drinking among women. This may include access to alcohol key workers or counselling services.
- All homeless people should be offered Hepatitis B and A vaccinations as well as seasonal Influenza vaccination. Existing vaccination campaigns conducted for the general population through the HSE could perhaps be expanded and adapted to the homeless population.
- A central point for information on health entitlements and how to access the various health services should be established. This information should be available also by phone. Blocks and barriers to health access could be reported and monitored through this central service.

## Addiction

- High rates of prescribed drug use in the context of illicit drug use indicates the need for tighter controls on prescription of benzodiazepines.
- The structure of the provision of methadone treatment mainly through centralised treatment centres should be reviewed for this client group. There is a need to orient services away from a centralised structure targeting mainly opiate addiction towards a community based system (closer to where people are) aimed at poly-substance abuse. Provision should be part of a comprehensive health service that has capacity to treat mental and physical ailments and aims to assist people to exit homelessness as a treatment goal. Different treatment services should be explored to see which are more effective in achieving set outcomes.
- The need for improved access to methadone maintenance among rough sleepers should be examined. Morbidity associated with serious alcohol and opiate addiction (e.g. blood borne viruses, dental problems and liver disease) should be screened for and treated in all homeless populations.
- More inpatient detox beds should be made available to reduce waiting lists.

## Accommodation

- Provision of additional resources to ensure the Housing First model is extended to support all chronically homeless people with multiple support needs.
- City and County Council accommodation for people with mental health needs is a priority in order to prevent the mentally ill becoming homeless.
- Stable, safe accommodation should be made available post detox to reduce the likelihood of relapse.
- Temporary accommodation that is supported (e.g. STAs) appears to be more favourable in terms of health care access than that which is not (e.g. Private Emergency Accommodation).

### Further research could usefully explore the following areas:

- The increase in use of secondary services in the context of increased access to primary care.
- The impact of reducing inpatient psychiatric beds on the treatment of severe mental illness among homeless people.
- The difference in specific morbidities and multi-morbidities among homeless and housed populations.
- The health service blocks to health care and treatment for homeless people.
- Risk factors associated with suicidality among homeless people.



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*“To be noticed. To be asked. Not to be invisible, just left there. It’s hard enough being homeless without being treated like you are on the bottom.”*

**-26 year old homeless woman accompanied by two children  
(2013 survey)**

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