Health and Homelessness

Health Snapshot Study of People Using Simon Services and Projects in Ireland

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Simon Communities of Ireland

The Simon Communities throughout Ireland provide the best possible care, accommodation and support for people experiencing homelessness and those at risk. Together, with people who are homeless, Simon tackles the root causes, promotes innovative responses and urges the government to fulfil their commitments. Simon delivers support and service to between 4,500 and 5,000 individuals and families who experience - or are at risk of - homelessness on an annual basis.

The Simon Communities of Ireland is an affiliation of local Communities in Cork, Dublin, Dundalk, Galway, the Midlands, the Mid West, the North West and the South East. In addition, the National Office performs a coordinating role in campaigning in the areas of housing/homeless policy and the wider poverty and social inclusion agenda; best practice in service delivery and working with people who are homeless; and in the area of full time volunteering promoting excellence and providing accredited training.

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Executive Summary

The majority of people who are homeless experience more health problems than the general population. However, in Ireland at least, there is a lack of specific information about the health of people who are homeless, in particular focussing on people at different stages of homelessness, including those at risk of homelessness.

This snapshot study attempts to bridge this information gap and inform the development of effective homeless and health services for people who are homeless in Ireland. The study is based on information collected by the eight Simon Communities across Ireland. In total, 788 people using Simon projects and services participated in the study during one week in summer 2010. The questionnaire covered a wide range of issues, including physical and mental health, drug and alcohol use, complex needs, access to medical services, challenging behaviour and self-harm.

Main findings

Profile of people

Gender: The majority of participants in this study are male, 78% compared to 22 % female.

Nationality: While the majority are Irish nationals, there are also a significant number of people from other nationalities, with more than 1 in every 7 respondents of a non-Irish nationality.

Age: Three quarters of those who participated in the snapshot study were aged between 26 and 55 years of age.

Health profile

The report clearly demonstrates high levels of ill health among people using Simon projects and services.

Physical Health: Nationally, 56% of people who use Simon projects and services have at least one diagnosed physical health condition. This study shows that respiratory diseases are common and cardiac and pulmonary problems are also prevalent. Rates of certain serious infectious diseases are significantly high including HIV and hepatitis C.

Mental Health: Fifty two per cent (52%) of all respondents have at least one diagnosed mental health condition. Depression is the most typical mental health condition. Twenty – eight per cent (28%) of all respondents or more than 1 in every 4 of people using Simon projects and services who participated in this snapshot study has a medical diagnosis of depression. The other most common mental health condition is Schizophrenia (9%).

Alcohol and Drug Use: Two-thirds (66%) of respondents use alcohol, with 30% of people having at least one complication arising from their alcohol use. Thirty-eight percent use drugs and 15% of people who participated in this snapshot study were using drugs intravenously.

Complex Needs and Dual Diagnosis: A significant proportion of respondents have multiple and overlapping health needs and experience complications arising from alcohol and/or drug use.

Twenty eight per cent (28%) of respondents have at least one diagnosed physical health condition and at least one mental health condition. In addition, 28% of respondents have a suspected 'dual diagnosis' involving a diagnosed mental health condition with complications arising from alcohol and/or drug use.

Accessing Medical Services: There are high levels of potential access to mainstream primary medical services with 91% of people registered with a GP and 84% holding medical cards. However, many respondents still access Accident and Emergency (A&E), with 16% having attended A&E at least once in the last month (June 2010).

Self-harm and Suicide: Fifteen per cent (15%) of people self –harm, 23% have recurring ideas about committing suicide and 8% (56 people) have attempted to commit suicide in the last 6 months.

Challenging behaviour[1]: Thirty four percent (34%) of people who use Simon projects and services are recorded as having "challenging or withdrawn behaviour". This may impact on people's ability to access appropriate medical, as well as drug and alcohol, treatment. Research suggests that many mainstream services are not always fully equipped to deal with people who present with "challenging" behaviour (FEANTSA, 2006).

Disability and Other Payments: Sixty – five percent (65%) of respondents are receiving one of the following; disability allowance, illness benefit or pension because of ill health, disability or old age pension. Thirty-five per cent (35%) are dependent on other sources of income, typically either social welfare or employment.

Habitual Residency Condition: A total of 48 people (6.5%) who were affected by the Habitual Residence Condition (HRC) were using Simon projects and services during the week in question.

Registered as Homeless: Of the study participants 65% were registered as homeless with the relevant local authority, while 35% were not registered as homeless.

Reason for Homelessness: Problematic personal alcohol use is viewed by respondents as one of the main reasons for their homelessness (19%). This is followed by family breakdown (14%), personal drug use (12%) and relationship breakdown (9%).

Length of Time Homeless: Study participants included both people who are homeless or who were formerly homeless as well as people at risk of homelessness. Of the people who are presently homeless, the vast majority are long-term homeless with just over 80% homeless for more than 6 months (the governments definition of long term homelessness), including 35.5 % who are homeless for more than 5 years. Of the people who were formerly homeless, more than half of the respondents were homeless for more than 5 years.

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[1] Challenging behaviour in this context ranges from social withdrawal to aggressive behaviour

Accommodation Type: The largest group of survey participants were staying in emergency accommodation (28%); followed by 15 % who were staying in high support housing and 12 % who were living in low support housing. However, when taking the following four categories together -rough sleeping, emergency accommodation, squats and bed and breakfasts- this reflected 35% of the sample who were living in vulnerable situations with minimal supports, exposed to high levels risk in terms of their health and drug and alcohol risk behaviours.

Recommendations

Notwithstanding the many and complex needs of many people who are homeless, the experience of homelessness and poor health is not inevitable. Research on homelessness and indeed the Simon Communities' experience of working with over 4,500 households every year demonstrates that with appropriate support people who are homeless can, and do, leave homelessness behind. In addition homelessness can also be prevented from occurring in the first place. Research indicates that exiting homelessness is the life event that has the greatest positive impact on the health of a person who is homeless (Culhane and Metraux, 2008; Culhane *et al*, 2007a).

Responding effectively to the needs of a person who is homeless requires a person centered response and the provision of accessible and flexible services that address the person's care, accommodation and support needs. To achieve this all services - statutory and non-statutory - must acknowledge their roles as funders and as service providers and work to ensure services are tailored to be more flexible and accessible to people who are homeless.

Recommendations focus on the following areas:

- Improving access to health care for people with complex needs.
- Improving access to drug and alcohol services for drug /alcohol users who are homeless.
- Improving access to homeless services for drug and alcohol users.
- Reducing A&E usage and hospital and prison stays.
- Ending inappropriate discharge practices.
- Achieving standardized needs assessment.
- Training for front line staff.
- Access to services for those affected by the Habitual Residence Condition.
- Further research on the pathways out of homelessness.

1. Introduction

This research report is the result of an undertaking by the eight local Simon Communities around Ireland and the National Office who came together during one week in the summer of 2010 to meet and interview or to review the records of 788 people using Simon projects and services. This report aims to capture some of the key findings, particularly in relation to health status, both physical and mental, drug and alcohol use and related health implications, access to medical services and the person's reasons for becoming homeless.

Understanding the health needs of people who become homeless is critical in developing, designing and improving not only homeless services but also health and other related services. It will also help in addressing long-term homelessness and in identifying the need for high-support housing for a significant number of people who are homeless in Ireland.

Health as a Human Right

The Simon Communities believe that every person has the right to enjoy the highest possible standard of health. The experience of homelessness may result in serious and persistent violations of this fundamental right.

As the US Institute of Medicine states in a report entitled *Homelessness, Health and Human Needs (1988)* homelessness is associated with poor health in three ways.

- First, some health problems can cause a person to become homeless. For example, poor physical or mental health can reduce a person's ability to find employment or earn an adequate income.
- Second, some health problems are consequences of homelessness. These include depression, poor nutrition, poor dental health, problematic drug and alcohol use and mental health problems. According to a variety of studies, people who are homeless also experience significantly higher rates of death, disability and chronic illness than the general population.
- Third, homelessness exacerbates and complicates the treatment of many health problems. People who are homeless have significantly less access to health services than the broader population. Reasons for this may include financial hardship; lack of transportation to medical facilities; lack of identification or a medical card; and difficulty maintaining appointments or treatment regimes.

It is anticipated that this snapshot study will identify some of the barriers to making the right to health a reality for people who are homeless in Ireland and developing effective measures to ensure that people who are homeless have equal and assured access to appropriate health care, including physical and mental health services, drug and alcohol rehabilitation as well as harm reduction services.

Policy context in Ireland

Health services and local authorities are the two lead statutory bodies with responsibility for addressing homelessness and the needs of people who are homeless in Ireland. The responsibilities of the health services are defined in two pieces of legislation. The Health Act 1953 imposed a duty on health boards (now Health Service Executive (HSE)) to provide assistance and shelter to people who are homeless. Under the Child Care Act, 1991, health services have a responsibility to provide for the care, welfare and accommodation of children and young people aged under 18 who are homeless. Under the Housing Act 1988 local authorities are empowered to respond to homelessness, including housing people who are homeless directly, by funding voluntary and co-operative bodies to house them, by providing advice and information to them, and by providing them with financial assistance to access private rented accommodation. The Department of Environment, Heritage and Local Government (DoEHLG) has the role of providing a national framework of policy, legislation and funding to underpin action to address homelessness at local or regional level. The overall national policy framework to address homelessness is set out in the Government's homelessness strategy, *The Way Home: A Strategy to Address Homelessness in Ireland 2008-2013,* which was published in August 2008 and the National Implementation Plan for the strategy, which was published in April 2009.

The Way Home sets out six strategic aims:

1. *Prevent homelessness*
2. *Eliminate the need to sleep rough*
3. *Eliminate long-term homelessness*
4. *Meet long term housing needs*
5. *Ensure effective services for homeless people, and*
6. *Better co-ordinate funding arrangements.*

(The Way Home, 2008, p7)

The Way Home reiterates the important role health services play for people who are homeless, both in preventing homelessness and in supporting people to move out of homelessness. As part of the National Homeless Strategy, the HSE aims to meet the health needs of people who are homeless through the roll-out of Primary Care Teams and Primary and Social Care Networks. The idea is that not to create a separate system for people who are homeless but that people who are homeless will access primary care through these Teams and Networks. More specifically, the Homeless Strategy National Implementation Plan sets out concrete priority actions aimed at ensuring people who are homeless or at risk of homelessness have access to appropriate health care, for example in relation to the provision of targeted mental health services to people who are homeless or the implementation of effective discharge policies from health institutions. The Government's response to addressing the health needs of people who are homeless has also been informed by the Expert Group on Mental Health Policy Report "A Vision for Change". This report recommends the establishment of community-based mental health teams (CMHT) that will allow for the provision of person centred, recovery oriented, holistic and multi-disciplinary mental health care at local level. The close link between homelessness and problematic alcohol and drug

use is highlighted in the National Drugs Strategy (interim) 2009-2016 (DoCRGA). The Strategy mentions people who are homeless as a specific target group and sets out to provide appropriate and timely treatment and rehabilitation services (including harm reduction services) tailored to individual needs.

The Simon Communities of Ireland welcome the Government's efforts in recent years to develop effective homelessness policies, including health policies targeted at people who are homeless in Ireland. As stated earlier, the aim of this report is to contribute to identifying potential gaps in the implementation of the National Homeless Strategy and providing recommendations on ways to ensure the provision of appropriate and accessible health care to people who are homeless in the future.

Report Layout

This report is also designed to aid the Simon Communities, policy makers and those interested in the issue to understand the full and sometimes complex health profile of people who become homeless. Although addressing a specific subset within the homeless population – those who use Simon projects and services– because of the large number of people interviewed right across Ireland, the report should be highly relevant in helping to understand the health needs of people who are homeless or at risk of homelessness in Ireland.

The report is structured in the following manner:

Section 1: Executive Summary and Introduction.

Section 2: Methodology: This discusses the methodology employed to carry out this research. This section is important to help understand the context, the nature of this research and the findings.

Section 3: Main Findings: This is the main section in the report. It sets out the main findings under the following headings:

- Gender
- Nationality
- Disability Allowance/Other Illness Benefit/ Pension
- HRC Affected
- Length of Time Homeless
- Current Accommodation Type
- Reasons First Became Homeless
- Physical Health
- Mental Health

- Alcohol Use
- Drug Use
- Complex Needs
- Access to Medical Services
- Challenging Behaviour
- Self-harm and Suicide

Where possible and research readily available, comparison is made with existing national and international research on these issues. However, because of the nature of this study, which contacted people using Simon projects and services at different stages of homelessness, including those at risk of homelessness and those formerly homeless and now settled, direct comparisons are often difficult with other research studies, which tend to focus on those in homeless settings, such as emergency accommodation, and people sleeping rough.

Section 4: Conclusions and Recommendations. This section draws together the main findings and makes suggestions on how to address the issues identified.

2. Methodology

Snapshot Study

This report is a snapshot study undertaken across all Simon projects and services. A snapshot is a 'point in time' picture during a particular sample time period, in this case one week. This snapshot report focuses on the profile and health needs of people using Simon projects and services. It does not claim to give a final picture of the profile and health needs of all people who use Simon projects and services and cannot be used to estimate the total number of people using services during the week in question or a longer period of time such as a calendar year. This snapshot study is, however, a significant sample at a 'point in time' and thus can be used as a basis to generalise about the health and support needs.

The information gathered for this report follows a relatively simple process of data gathering. A questionnaire was designed based on work already completed by Cork and Dublin Simon Communities in 2009. The questionnaires together with participant information and consent forms were circulated to all eight Simon Communities in Ireland. A unique identifier was recorded for each individual and was used to ensure anonymity and to reduce the risk of double counting. Two of the communities required additional support from the researcher but otherwise the questionnaires were completed autonomously by the Communities themselves who oversaw the process of interviews. Consent was negotiated locally by each individual Community.

In total 788 questionnaires were completed during the week of the 26th July to the 1st August, 2010. In general, the more urban and longer established Simon Communities, those in contact with a greater number of people returned the greater number of questionnaires. As mentioned, the people who participated in the study constitutes a sample of those using Simon projects and services and does not reflect or represent the total number of people who were using Simon projects and services around the country during the week in question. This is for a number of reasons, including people who did not wish to participate in the research, the limited time and resources of local Simon Communities in carrying out this research and the difficulty of interviewing every person who is using Simon projects and services. The Simon Communities collectively work with 4,500 to 5,000 individuals every year.

In summary, the research has used a form of sampling called convenience sampling. This is a type of sampling which involves the sample being drawn from that part of the population which is close to hand i.e. a sample population selected because it is readily available and convenient. Using such a sampling technique means that the survey cannot scientifically make generalisations about all people who are homeless. However, it provides a valuable insight into the health needs of a significant proportion of people using Simon projects and services at a point in time.

The breakdown of number of people interviewed under each Simon Community is as follows:

Number of people interviewed by Community		
Region	**Number of Forms**	**% of total**
Cork	188	24%
Dublin	349	44%
Dundalk	17	2%
Galway	93	12%
Midlands	47	6%
Mid West	9	1%
North West	79	10%
South East	6	1%

There were some small differences in the approach to data collection adopted by some of the Simon Communities. In filling in the questionnaires, the local Simon Communities either interviewed the participants face to face (as in the case of Dundalk and South East) or analysed the records of people using their services and projects at the time of admission/contact and filled in the forms based on this data (as in the case of the Midlands) or adopted a mix of these (most common approach). Data was returned either in the form of returned questionnaires, which were imputed into excel sheets by the researcher, or returned as completed excel sheets.

Participants in this study were met in a variety of contexts, including Simon day centres; emergency, transitional, supported and long-term housing; outreach and tenancy sustainment services; and in people's own lodgings.

Meaning of Homeless

There are three groups of people included in this research:

- People who are currently homeless
- People who were previously homeless and need support to maintain their home
- People who are at risk of becoming homeless.

All 3 groups fall under the ETHOS definition of homelessness (see table below), which has been adopted by the Simon Communities of Ireland and indeed the Government in the National Homeless Strategy, *The Way Home*. In all Simon Communities a mix of these 3 groups of people were met and interviewed. It is important to take this into account when making comparisons with other research looking at people

who are homeless which may have focused solely on particular target groups e.g. rough sleepers or those in emergency accommodation.

The European Typology of Homelessness and Housing Exclusion (ETHOS)		
Conceptual Category	**Operational Category**	**Living Situation**
Roofless	1.People living rough	1.1 Public space or external space
	2. People in emergency accommodation	2.1 Night shelter
Houseless	3.People in accommodation for the homeless	3.1 Homeless hostel 3.2 Temporary accommodation 3.3 Transitional supported accommodation
	4. People in Women's Shelter	4.1 Women's shelter accommodation
	5. People in accommodation for immigrants	5.1 Temporary accommodation/ reception centres 5.2 Migrant workers accommodation
	6. People due to be released from institutions	6.1 Penal institutions 6.2 Medical institutions 6.3 Children's institutions/homes
	7. People receiving longer term support (due to homelessness)	7.1 Residential care for older homeless people 7.2 Supported accommodation for formerly homeless people
Insecure	8. People living in insecure Accommodation	8.1 Temporarily with family/friends 8.2 No legal (sub)tenancy 8.3 Illegal occupation of land
	9. People living under threat of eviction	9.1 Legal orders enforced (rented) 9.2 Re-possession orders (owned)
	10. People living under threat of eviction	10.1 Police recorded incidents
Inadequate	11. People living in temporary/non conventional structures	11.1 Mobile homes 11.2 Non-conventional building 11.3 Temporary structure
	12. People living in unfit housing	12.1 Occupied dwellings unfit for habitation
	13. People living in extreme Overcrowding	13.1 Highest national norm of overcrowding

Limitations

General

Analysis about homelessness today, including the Government's own National Homeless Strategy *"The Way Home*", tends to discredit individualistic explanations as the sole causes of homelessness. It is now accepted across the board amongst researchers, policy makers and social science researchers that homelessness is the outcome of a dynamic interaction between individual and structural causes. Vulnerability/risk factors include housing related problems, unstable employment, family status, ethnic status, relationship breakdown and problem drug and alcohol use. Reasons may be of a structural, institutional, relationship-related or a personal nature.

Thus, caution is suggested by some when reviewing studies of this nature. Some social scientists believe that medical diagnosis is the start of social exclusion and that discrimination arises because of the diagnosis, not as a result of the condition itself. Furthermore, it is said that the medical model upholds other negative aspects of professional culture that can undermine effective outcomes for those who are socially excluded.

Snow et al caution that there is a danger that a de-contextualised health status report of people who are homeless may be used to stigmatise people. Snow warns that such studies can lead to *"… a truncated, de-contextualized, and over pathologised picture of the homeless, a picture that tells us relatively little about life on the streets as it is actually lived and experienced and that glosses over the highly adaptive, resourceful, and creative character of many of the homeless, some of which may in fact be mistakenly perceived as pathological (1994: 469)."*

Finally as O'Sullivan (2008) notes "*...cross-sectional studies over-estimate the severity of homelessness, as at any point in time, those who are long-term or chronically homeless will be overrepresented in such research. Emerging longitudinal research highlight the dynamic nature of homelessness with the majority both entering and exiting homelessness relatively speedily*."

In relation to the general limitations identified by academics and researchers above, it is worth highlighting that the purpose of this report is to add to the existing body of knowledge by providing useful information in relation to the health needs of people who become homeless. This is critical to addressing long-term homelessness and in identifying the need for high-support housing for a significant number of people who are homeless in Ireland.

Specific to this research

The questionnaire for this snapshot study was designed internally utilising in-house expertise. It was not designed or administered by health professionals and thus the findings are indicative only. This is especially relevant to the question on the "undiagnosed" mental and physical health status assessments of people who become homeless. These assessments made have either been supplied by the person themselves or assessments have been made by a Simon Community staff member.

In the case that the person who is homeless who is making an assessment of their own health interestingly research finds that "self-perceived health status" indicators when gathering information on the health situation of people who are homeless tend to underestimate the extent of health (especially mental health) problems experienced by those interviewed. It is suggested this is because either "*...people with a low opinion of themselves have a tendency to minimise their health problems and to adjust their standards downwards to fit their circumstances...*" and because self-reporting is "*...bound to be used by the individual to present himself towards other people the way it suits him the most*" (FEANTSA 2006).

In the case of the "undiagnosed section" being completed by the interviewers, the reader should consider that those carrying out the interviews were not health professionals and they are merely expressing

opinions, albeit opinions formed over a period of time working with the individual/s in question. In addition, as the persons carrying out the research are generally known to the interviewee this may affect the respondents' willingness to disclose some personal information for example services which prohibit illegal drug use on their premises may find that that people who use illegal drugs are less likely to disclose drug use patterns.

One final caveat is in relation to alcohol and drug use and the ability to draw conclusions about problem drug and alcohol use[2]. The interview form does not ask about the extent, frequency or quantity of drug or alcohol use or ask whether a person who may presently not be using alcohol or other drugs has been a "problematic" user in the past. This might be considered a gap in the data and restricts the extent of conclusions that can be drawn about problematic drug and alcohol use.

[2] A problem drug user is *"any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and dependence, as a consequence of his or her use of drugs or other chemical substances" (*Advisory Council on the Misuse of Drugs, 1982).

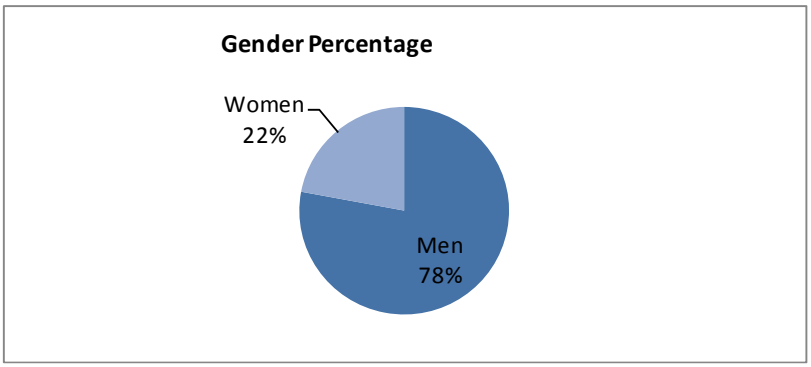
3. Main Findings

In this section the findings of the report are set out under separate headings. Some graphs and tables are used to aid analysis. Percentages are given as a percentage of the number of respondents to the question and exclude unknowns.

3.1 Gender

The overwhelming majority of participants in this study are male. Over the week in question 174 women and 614 men were interviewed for this research (22% female and 78% male). This is obviously significantly different from the approximately equal proportion of males to females in the general population.

The breakdown is as follows:



Comparison

The Homeless Agency's 2008 *Counted In* study had 68% male and 32% female respondents. This finding is supported by the National Advisory Committee on Drugs (NACD) report on homelessness and drug use in Ireland (Lawless and Corr, 2005), which covered the areas of Cork, Dublin, Limerick and Galway. In this report 69% of respondents were male and 31% were female.

This finding suggests that Simon projects and services generally work with fewer women and more men than the average homeless services in Dublin.

3.2 Nationality/ Ethnic Group

Simon projects and services work with people on a need basis and do not restrict access to services based on nationality. While the overwhelming majority of people using Simon projects and services are Irish nationals, there are also a significant number of people from other nationalities, with more than 1 in every

7 respondents of a non-Irish nationality. Simon projects and services also attempted to separately record whether the person was an Irish Traveller. However, because the question was about nationality rather than ethnicity and did not give options, people from a Traveller background may have been recorded as Irish.

Nationality		
Nationality	**Number**	**% of total (excluding unknowns)**
Irish	650	85%
UK	47	6%
European Union - East European Area	40	5%
Irish Travellers	11	1.4%
Africa	7	1%
European Union – Central Europe	5	0.6%
Other	7	1%
Unknown - returns where the nationality was not identified	21	

Comparison

These results are broadly in line with *Counted In* (2008). In that count, most adults using homeless services (84%) were Irish nationals. However, a larger minority were non-EU citizens (6%) in the Homeless Agency Count compared to this Simon survey (2%), which may reflect the urban bias of the Homeless Agency study i.e. people from other nationalities may be more inclined to travel to capital cities. It is important to note that *Counted In* (2008) found a significant number of non Irish-nationals amongst rough sleepers (38% of all rough sleeper in this count) in Dublin.

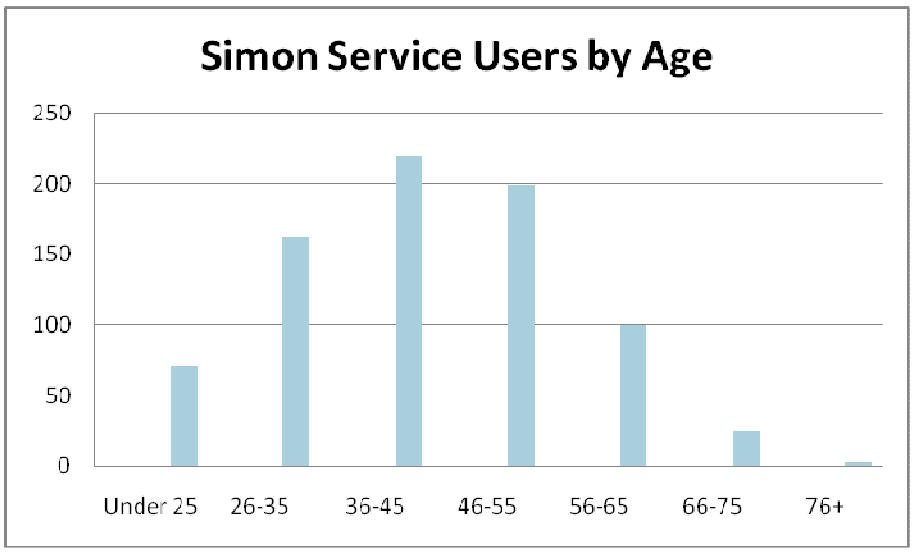
In the NACD study (Lawless and Corr, 2005) which examined homelessness in Cork, Galway and Limerick as well as Dublin, the majority of the total study population (89%) was Irish with the remaining 11% largely comprising of individuals from Northern Ireland, England, and Scotland. However in Cork, only three quarters (75%) of respondents were from Ireland. It is imprtant to note that this study was undertaken over 5 years ago and published in 2005.

3.3 Age Profile

People who use Simon projects and services who were interviewed were analysed by age group. The table below sets out the numbers and percentage of people contacted for this survey. The average age of those who participated in this study was 42.5 years.

Age Profile								
Age	**Under 25 (18-25yrs)**	**26-35**	**36-45**	**46-55**	**56-65**	**66-75**	**76+**	**Unknown**
Totals	71	162	219	199	100	25	3	9
Percentage	9%	21%	28%	26%	13%	3%	0%	-

Thirty percent (30%) of people in this study are under 35 years of age with 9% between 18 and 25 years old. Fifty four percent (54%) are aged between 36 and 55 years. Twenty six per cent (26%) are aged between 56 and 75, of these 3% were aged between 66 and 75 years of age.



Comparison

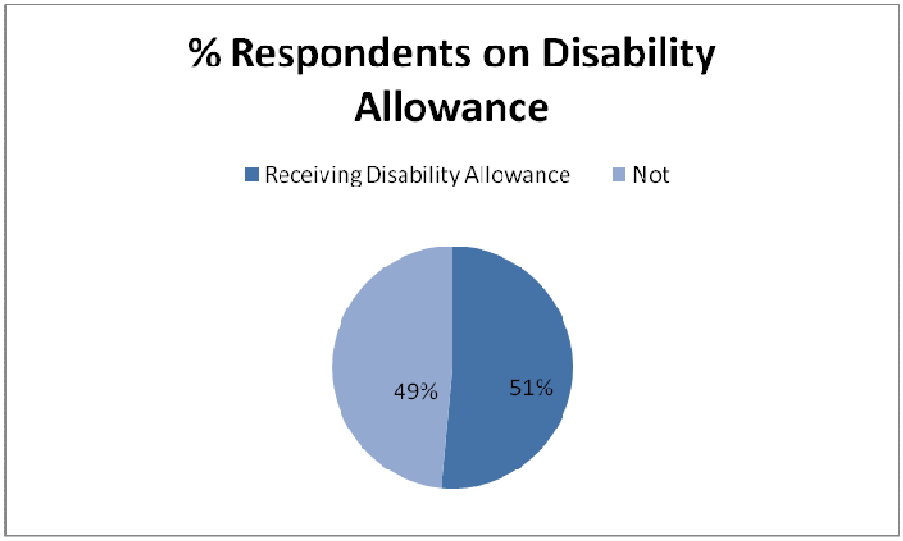
The sample of people who use Simon projects and services is older than the age group included in similar studies. *Counted In* (2008) shows that 44.5% of adults who are homeless in Dublin are under 35 while only 30% of people who use Simon projects and services are under 35. Simon Communities in Ireland work with a higher percentage of people aged between 46 and 65 years of age (39% of the total sample) compared to the homeless population in the *Counted In* sample which found 27.3% of adults who are homeless are aged between 46 and 65 years.

In the NACD 2005 study, 29% of respondents were under 25, 26% were aged between 25-34 years, 19% were aged 35-44 years and 26% were aged 45 years plus. In comparison with this sample, the Simon Communities appear to work with a significantly older age group.

3.4 Disability Allowance/ Other Illness Benefit/ Pension

A total of 48 people using Simon projects and services (6% of respondents) were entitled to an old age pension. Four hundred people (51.4% of respondents) were entitled to a disability allowance. Thirty three of a sample (7.5%) indicated that they were entitled to other illness related benefits (this excludes people using Simon services and projects in Dublin where it was found that the results of this question were unreliable due to confusion about the question).

In other words approximately 65% of respondents were receiving one of the following; disability allowance, illness benefit or pension because of ill health, disability or old age. Thirty – five per cent (35%) were dependent on other sources of income, typically either social welfare or employment.



Comparison

The findings above contrast with *Counted In* (2008) which reported that 24% of people in homeless services in Dublin received Disability Allowance while more than 51% of people using Simon projects and services receive a disability allowance. This indicates that Simon projects and services tend to work with people who are homeless who present with complex needs and are likely to require a higher level of support compared to the average support needs of people who are homeless in Ireland.

3.5 HRC Affected

The meaning of the Habitual Residence Condition has been set out in legislation. Section 246 of the Social Welfare Consolidation Act 2005 provides that:

"It shall be presumed, until the contrary is shown, that a person is not habitually resident in the State at the date of the making of the application concerned unless he has been present in the State or any other part of the Common Travel Area for a continuous period of 2 years ending on that date."

Section 30 of the Social Welfare and Pensions Act 2007 added that:

"(4) Notwithstanding the presumption in subsection (1), a deciding officer or the Executive, when determining whether a person is habitually resident in the State, shall take into consideration all the circumstances of the case including, in particular, the following:

a. the length and continuity of residence in the State or in any other particular country;

b. the length and purpose of any absence from the State;

c. the nature and pattern of the person's employment;

d. the person's main centre of interest, and

e. the future intentions of the person concerned as they appear from all the circumstances."

Section 15 of the Social Welfare and Pensions (No. 2) Act 2009 introduced additional provisions allowing further exemptions, most importantly perhaps *exempting an Irish citizen from its provisons*.

As stated in section 3.2 of this report, the Simon Communities provide services to people based on need and do not discriminate on the basis of nationality. People who are HRC affected are often faced with the additional challenges; they are not only ineligible for social welfare support but also risk not being eligible to access emergency homeless accommodation. This is a cause for concern as Irish nationals and non-Irish nationals who are HRC affected do not have the same rights and entitlements to welfare or housing, and thus may become homeless in the first place and/or face additional barriers to exiting homelessness.

A total of 48 (6.5%) people who were using Simon projects and services during the week in question disclosed that they were affected by the Habitual Residence Condition .There were 54 'unknowns' perhaps indicating a reluctance to disclose this information. Twenty eight of these 48 people who were HRC affected were using Cork Simon projects and services.

The research shows that the 6.5% of people who use Simon projects and services for whom the Habitual Residence Condition is one of the reasons why they became homeless, tend to have lower health support needs, compared to those who are homeless because of a significant life event, and thus require different forms of support. Caution should be exercised in relation to these figures as people may have been reluctant to disclose their HRC status for fear of implications.

3.6 Registered as Homeless

Of the survey participants 497 or 65% were registered as homeless with the relevant local authority, while 271 people or 35% of the total were not registered as homeless (with 20 unknowns). Removing the people recorded in this sample who have never identified themselves as homeless (61 people), e.g. people who were at risk of homelessness, gives an overall percentage of 69% of people presently or formerly homeless who were registered as homeless and 31% of people presently or formerly homeless who are not registered as homeless. As one might expect people using tenancy sustainment services show much lower levels of registration as homeless compared to those in "homeless" accommodation. In addition, those affected by the HRC may not be registered as "homeless".

Comparison

This figure is fairly consistent with the figure in the NACD 2005 study which found that 68% of people interviewed for its research were registered as homeless with the relevant local authority.

3.7 Length of Time Homeless

The Simon Communities work with people presently homeless, including people who are long-term homeless (i.e. which according to the government is 6 months plus), *and* those who are at risk of homelessness or were formerly homeless. The report separately analyses the length of time homeless of those who are presently homeless and those who are formerly homeless.

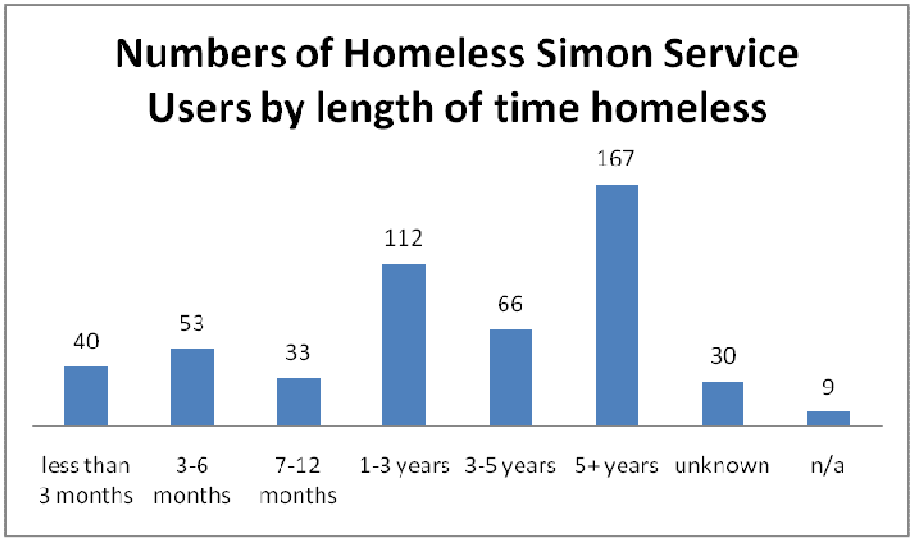
Presently Homeless

Of the people presently homeless their length of time homeless is shown below:

Length of time homeless			
Length of Time Homeless	**Number and %**	**Length of Time Homeless**	**Number and %**
Less than 3 months	40 – 8.5%	3-5 years	66 – 14%
3-6 months	53 – 11%	5+ years	167 – 35.5%
7-12 months	33 - 7%	unknown[3]	30
1-3 years	112 – 24%	N/A	9

Long term homelessness (6 months plus) was high in this study with 80.5% of people reporting being homeless for more than 6 months. Of these, 35.5 % reported being homeless for 5+ years.

[3] This includes all 19 residents in Dublin Simon Community's Canal Road residential service, where staff was uncertain about how to classify residents staying there.



Comparison

Counted In records 'length of time homeless' of adults who are homeless in Dublin under slightly different headings. The findings for the 2008 *Counted In* survey are as follows:

Less than 6 months: 16.1%

6 months to 1 year: 14.3%

1- 3 years: 23.3%

3-5 years: 15.0%

Over 5 years: 31.4%

When compared with *Counted In* (2008) which reported that 31.4% were homeless for more than 5 years the Simon sample is higher at 35.5%. The Simon sample also had more people who were homeless for less than six months 19.5% when compared to 16.1% in *Counted In.*

Formerly Homeless

Of the people who were formerly homeless and who are now being supported by Simon Tenancy Sustainment services, their length of time homeless is shown below:

Length of time formerly homeless			
Length of Time Homeless	**Number and %**	**Length of Time Homeless**	**Number and %**
Less than 3 months	13 - 6%	3-5 years	54 – 24.5%
3-6 months	22 - 10%	5+ years	73 – 33.5%
7-12 months	12 – 5.5%	Unknown	44
1-3 years	45 – 20.5%	N/A	15

The table indicates that Simon projects and services work with people who are homeless for a significant period of time, with more than half of the respondents indicating that they have been homeless for more than 3 years (58%).

3.8 Current Accommodation Type

Respondents in this snapshot study reported the following accommodation types:

Current Accommodation Type					
Accommodation Type	**Number and %**	**Accommodation Type**	**Number and %**	**Accommodation Type**	**Number and %**
Rough Sleeping	29 4%	Low Support Housing	98 12%	Local Authority - Supported	85 11%
Emergency Accommodation	223 28%	Medium Support Housing	0 0%	Local Authority – No Support	32 4%
Squat	10 1%	Private Rented – Supported	70 9%	Transitional Accommodation	32 4%
Bed and Breakfast	15 2%	Private Rented- No Support	46 6%	Other	22 3%
High Support Housing	118 15%	Residential Rehab/ Detox	9 1%	Unknown	0

As can be seen above there is a relatively low percentage of people who participated in this research who were sleeping rough (4%). This is largely due to the lack of resources available and the difficulties in administering the questionnaire to this hard to reach group. However, when taking the first four categories together (rough sleeping, emergency accommodation, squats and bed and breakfasts) this

accounts for 35% of this sample who are living in vulnerable situations with minimal supports, exposed to high levels risk in terms of their health and drug and alcohol use. The NACD (2005) report clearly highlights the link between risk behaviour and vulnerable living situations.

In addition, 51% were living in accommodation with some level of support this included 15 % residing in high support housing, 12 % living in low support housing, 11% living in local authority accommodation with support and 9% living in the private rented sector with support. Four percent were currently residing in transitional accommodation and 1% were either in detoxification or rehabilitation services. Only 10% were living independently with no support (6% in the private rented sector and 4% in local authority housing).

3.9 Reasons First Became Homeless

Respondents[4] were also asked to give the primary and secondary reasons why they may have become homeless.

Primary

The primary reasons for becoming homeless are presented in the table below:

Reasons for becoming homeless					
Reasons for Becoming Homeless	**Number**	**Reasons for Becoming Homeless**	**Number**	**Reasons for Becoming Homeless**	**Number**
Never Experienced Homelessness[5]	61	Evicted from Local Authority	5	Physical Health Problems	3
Alcohol Use- Family	14	Evicted from Private Rented	13	Physical/ Sexual Abuse	9
Alcohol Use- Personal	116	Family Conflict	84	Pressure from Local Community	1
Asked to Leave by Family	11	Leaving Institution	8	Relationship Breakdown	52
Court Order/ Notice to Quit	1	Leaving Prison	8	Told to go by Landlord	7
Domestic Violence	9	Mental/ Psychiatric Issues – Family	5	Unfit Accommodation	15
Drug Use – Family	10	Mental Psychiatric Issues- Personal	39	Other	32
Drug Use – Personal	69	Money Problems	11	Unknown including Cork	196
Evicted due to Anti-Social Behaviour	1	Overcrowded Accommodation	8	Unknown excluding Cork	8

[4] Due to challenges in implementing this part of the questionnaire it was not possible to include to views of people using Cork Simon Community services

[5] Those who have "never experienced homelessness" are generally those who are at risk of homelessness contacted by Simon Tenancy Sustainment services.

With regard to the primary issues as to why the people using Simon projects and services became homeless, the issues in order of importance were as follows:

Primary Reasons for homeless in order of importance	
Alcohol Use (personal) – 22%	Family Conflict – 16%
Drug Use (personal) – 13%	Relationship Breakdown -10%
Tenancy Issues[6] - 9%	Mental/ Psychiatric Issues (Personal) – 7%
Family's Drug/ Alcohol/Psychiatric Issues – 5%	Leaving Prison/ Institution – 3%
Money Problems – 2%	Domestic Violence – 2%
Physical/ Sexual Abuse – 2%	Physical Health -1%
Other- 6%	

The table shows that for most people, the primary reasons for homelessness were not related to their health, with only 1% indicating physical health as the primary reason and 7% indicating personal mental/psychiatric issues as a primary reason for becoming homeless. In contrast, 16% indicated family conflict and 10% indicated relationship breakdown as the primary reason for their homelessness. However, problematic alcohol and drug use were also indicated as important reasons for becoming homeless with 22% and 13 % respectively.

Secondary

The research also recorded secondary reasons for becoming homeless. This information is presented in the table below:

Reasons for becoming homeless					
Reasons for Becoming Homeless	**Number**	**Reasons for Becoming Homeless**	**Number**	**Reasons for Becoming Homeless**	**Number**
Never Experienced Homeless	61	Evicted from Local Authority	1	Physical Health Problems	2
Alcohol Use- Family	6	Evicted from Private Rented	5	Physical/ Sexual Abuse	4
Alcohol Use- Personal	50	Family Conflict	40	Pressure from Local Community	2
Asked to Leave by Family	25	Leaving Institution	8	Relationship Breakdown	24
Court Order/ Notice to Quit	1	Leaving Prison	8	Told to go by Landlord	7
Domestic Violence	7	Mental/ Psychiatric Issues – Family	4	Unfit Accommodation	5
Drug Use – Family	4	Mental Psychiatric Issues- Personal	26	Other	12
Drug Use – Personal	38	Money Problems	12	No secondary reason including Cork	433
Evicted due to Anti-Social Behaviour	2	Overcrowded Accommodation	1	No secondary reason excluding Cork	245

[6] Reasons under this heading include Overcrowded/ Unsatisfactory Accommodation, Evicted from Private and Local Authority Accommodation and being told to leave by Landlord

The overview of secondary reasons for becoming homeless supports the finding that physical health is not one of the main reasons for homelessness of the people interviewed in this snapshot study, with only 2 people indicating physical health as a main reason for homelessness. These results support the earlier findings focussing on alcohol use as a reason for homelessness (total of 50 respondents), followed by family conflict (40 people), personal drug use (38 people) and relationship breakdown (24 people).

Combined

By combining the primary and secondary reasons why people using Simon projects and services become homeless, the following reasons are identified in the table below:

Reasons for becoming homeless					
Reasons for Becoming Homeless	**Number and %**	**Reasons for Becoming Homeless**	**Number and %**	**Reasons for Becoming Homeless**	**Number and %**
Never Experienced Homeless	61 7%	Evicted from Local Authority	6 1%	Physical Health Problems	5 1%
Alcohol Use- Family	20 2%	Evicted from Private Rented	18 2%	Physical/ Sexual Abuse	13 1%
Alcohol Use- Personal	166 19%	Family Conflict	124 14%	Pressure from Local Community	3 0%
Asked to Leave by Family	36 4%	Leaving Institution	16 2%	Relationship Breakdown	76 9%
Court Order/ Notice to Quit	2 0%	Leaving Prison	16 2%	Told to go by Landlord	14 2%
Domestic Violence	16 2%	Mental/ Psychiatric Issues – Family	9 1%	Unfit Accommodation	20 2%
Drug Use – Family	14 2%	Mental Psychiatric Issues- Personal	65 7%	Other	44 5%
Drug Use – Personal	111 12%	Money Problems	23 3%	Total number of reasons	890 100%
Evicted due to Anti-Social Behaviour	3 0%	Overcrowded Accommodation	9 1%		

The combined results confirm that problematic personal alcohol use is viewed by respondents as one of the main reasons for their homelessness (19%). This is followed by family breakdown (14%), personal drug use (12%) and relationship breakdown (9%).

Comparison

In the NACD (2005) study the question was also asked as to the reason why the person became homeless, using the same categories as headings. In contrast to the Simon survey, an even larger proportion of respondents in this study indicated relationship breakdown (24%) as the main reason for homelessness, followed by personal drug use (19%). Problematic personal alcohol use was also indicated by 13% of respondents in the NACD study compared to the 19% in the Simon sample. Only 3% said

their personal mental illness was a factor in the NACD study while this percentage is 7 % in the Simon sample.

The importance of mental health as a reason for homelessness was highlighted in a survey of people who are homeless in Northern Ireland. According to Fountain and Howes (2002) mental health problems contribute to homelessness and make finding suitable and secure accommodation difficult, with one in five people citing mental health problems as a factor in becoming homeless.

3.10 Physical Health

Study participants were asked about the extent of diagnosed and undiagnosed physical health conditions that they were presently experiencing. In the case of undiagnosed physical health conditions people were either asked about their present state of health or the interviewers made their best assessment and some conclusions were drawn.

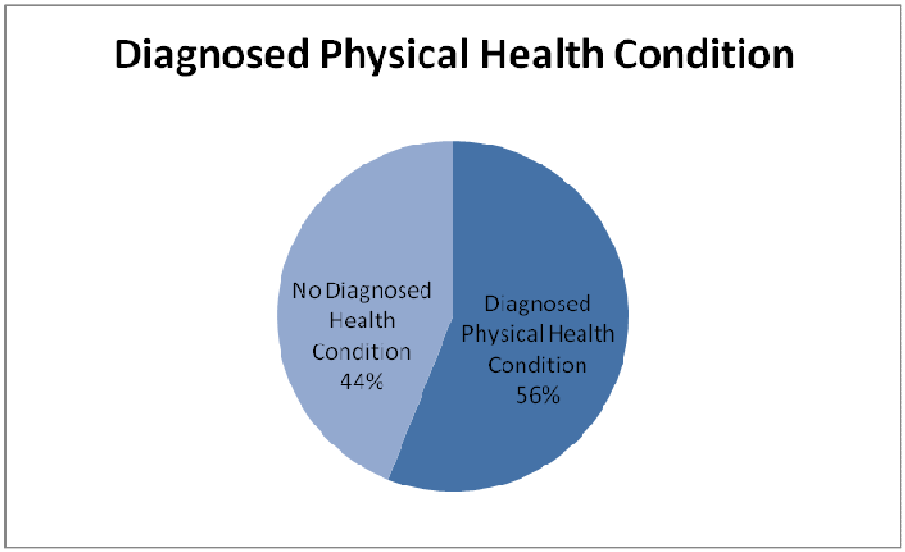
Diagnosed Physical Health Conditions

In the case of diagnosed physical health conditions respondents were able to identify up to four physical health conditions. The following conditions were identified:

Diagnosed Physical Health Conditions									
Health Condition	No.	Health Condition	No.	Health Condition	No.	Health Condition	No.	Health Condition	No.
None	346	Chronic Fatigue Syndrome	5	Gangrene	1	Irritable Bowel Syndrome	15	Pneumonia	1
Anaemia	11	Pulmonary Disease (COPD)	8	Gastroenteritis	9	Jaundice	6	Pressure Sores	11
Angina	21	Cirrhosis (Liver Disease)	24	Glaucoma	5	Kidney Infection	13	Psoriasis	7
Arthritis	27	Conjunctivitis	3	Haemorrhoids	1	Lymphoma	2	Septicaemia	2
Asthma	62	Constipation	9	Hardened Arteries	2	Migraine	10	Sexual Health	5
Broken bones	38	Cuts & Bleeding	23	Head Injury	27	Minor Stroke	17	Slipped Disc	10
Cancer	9	Deafness & Hearing Problems	25	Hepatitis B	7	Motor Neuron Disease	1	Spinal Muscular Atrophy	4
Cardiovascular Disease	38	Dental Conditions	55	Hepatitis C	70	Muscular Dystrophy	1	Tuberculosis	2
Cataracts	5	Developmental Amnesia	6	Hernia	7	Osteoporosis	4	Urinary Tract Infection	1
Cerebral Palsy	1	Diabetes	21	High Blood Pressure	45	Parkinson's Disease	2	Varicose Veins	5
Chiropody Conditions	21	Epilepsy	36	HIV	15	Peptic Ulcer	14	Vertigo	8
		Gallstones	2	Incontinence	15	Pleurisy	3	Total No. of Phys Health Conditions	798

In total in the Simon research 56% of people who use Simon projects and services had at least one diagnosed physical health condition. The main physical health conditions recorded were Hepatitis C (9%), Asthma (8%), Dental Conditions (7%), and High Blood pressure (6%), Cardiovascular Disease (5%), Broken Bones (5%), Arthritis (3%), Deafness and Hearing Problems (3%) Cirrhosis (3%), and Cuts and Bleeding (3%).

These findings contrast to a certain extent with the earlier finding that only 1% of respondents indicated physical health as the main reason for their homelessness. This might be explained by the fact that people did not indicate their physical health as a problem in relation to their homelessness despite suffering from physical illness already. However, it might also suggest that the experience of homelessness has a significant negative impact on the physical health of people and that their health status significantly deteriorated since the start of their homelessness experience.



Comparison

Some comparisons can be made with a recent study completed in Dublin in 2008 by O'Carrroll and O'Reilly which focused on people in emergency accommodation. The researchers interviewed 356 people staying in 22 hostels and Bed and Breakfasts in Dublin City centre, and found the presence of one mental health or physical health problem in 84% of interviewees.

In terms of physical health the main conditions recorded in the O'Carroll and O'Reilly study were all diagnosed health conditions and were as follows: Dental problems (53%), Asthma (23%), Foot problems (21%), Respiratory disease (16%), Skin problems (14%), Hypertension (14%), Arthritis (14%), Peptic ulcer disease (11%), Epilepsy (8%), Heart disease (6%), Tuberculosis (3%) and Diabetes (1%), and high rates of blood-borne diseases were also recorded, with Hepatitis C at 36%, HIV positive recorded at 6%and Hepatitis-B at 5%.

The NACD study found that 90% percent of respondents reported suffering from one or more physical complaints. However, there is no separation of diagnosed and undiagnosed health issues in this research.

The generally lower rates of physical ill health among people who use Simon projects and services might be explained by the fact that the O'Carroll study was completed in emergency accommodation where people experience some of the most extreme forms of homelessness and the NACD study also interviewed people in extreme forms of homelessness.

Undiagnosed physical health conditions

Undiagnosed physical health conditions were also recorded in the Simon study. Respondents were able to identify up to two undiagnosed physical health conditions. In total further disclosures by interviewees or observations by the Simon project staff identified 36% of people who use Simon projects and services as having undiagnosed physical health conditions.

The results are set out below:

Number of Undiagnosed Physical Health Conditions Observed							
Health Condition	No.	Health Condition	No.	Health Condition	No.	Health Condition	No
None	507	Eye Disorders	27	Immune Disorders	8	Respiratory Disorders	25
Blood Disorders	4	Fatigue	46	Long Term Physical Impairment	34	Skin Disorder	16
Digestive Disorders	39	Heart	14	Muscles & Bone Disorders	22	Urinary Problems	14
Ear, Nose & Throat	18	Hepatic	8	Neurological Disorders	12	Wounds and Injuries	35

The highest identified undiagnosed physical health conditions are fatigue (6%), digestive disorders (5%), long term physical impairment (4%) and eye (3%), respiratory (3%), muscles and bone (3%) disorders. It is important to note that just because these conditions are undiagnosed does not mean that they do not warrant medical intervention and treatment.

3.11 Mental health

Respondents were asked about the extent of diagnosed and undiagnosed mental health conditions that they were presently experiencing. In the case of undiagnosed mental health conditions users were either asked about their present state of health or, from the interviews and review of records, an assessment was made and some conclusions were drawn.

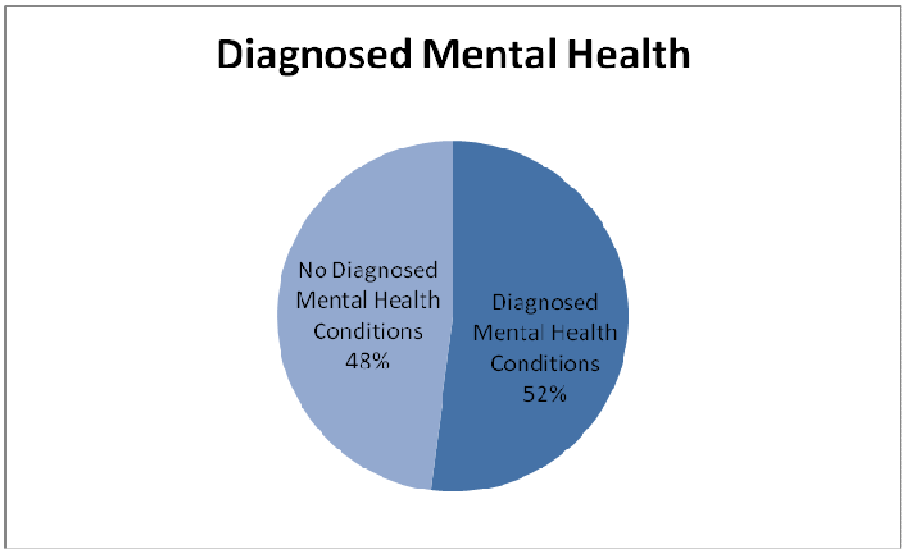
Diagnosed Mental Health

In the case of diagnosed mental health conditions, respondents were able to identify up to four mental health conditions. The following conditions were found to be experienced by people who use Simon projects and services:

Diagnosed Mental Health Conditions									
Health Condition	No.	Health Condition	No.	Health Condition	No.	Health Condition	No	Health Condition	No.
None	377	Binge Eating	7	Bulimia	2	Panic Attacks	55	Social Anxiety Disorder	37
ADD and ADHD	9	Dementia	6	Delusional Disorder	4	Phobias	11	Substance Induced Psychotic Disorder	16
Alzheimer's Disease	1	Bipolar Disorder	26	Depression	227	Post Traumatic Stress Disorder	8	Unknown	10
Anorexia Nervosa	2	Borderline Personality Disorder	15	Mild Cognitive Impairment	34	Schizophrenia	67	Total No. of Mental Health Conditions	561
Autism	2	Brief Psychotic Disorder	10	Obsessive Compulsive Disorder	8	Seasonal Affective Disorder (SAD)	3	/	/

In total 52% of all respondents have a diagnosed mental health condition. Depression is the most typical mental health condition. Twenty eight percent (28%) of all respondents or more than 1 in every 4 of people using Simon projects and services is medically diagnosed as experiencing depression. The other most common mental health conditions are schizophrenia (9%), panic attacks (7%), social anxiety disorder (5%), mild cognitive impairment (4%) and bi-polar disorder (3%).

The high prevalence of mental health conditions amongst the survey participants (52%) again contrasts to a certain extent with the earlier finding that only 7% indicated mental health as one of the main reasons for their homelessness. Similarly to physical health, this could mean that people simply did not consider their mental health condition as an important contributor to their homelessness. This may also indicate that the experience of homelessness severely affects the mental health of people.



Comparison

A comparison can be made with the Dublin 2008 study by O'Carrroll and O'Reilly mentioned previously, which assessed diagnosed ill health. That research found that 51% of interviewees were experiencing depression, 42% were experiencing anxiety and 11% were diagnosed with schizophrenia.

The NACD 2005 study indicated that *"nearly one-in-two of the study population reported having concerns about their psychiatric health. Less than half of the respondents reported having undergone a psychiatric assessment (42%)"*. Thirty per cent (30%) had been admitted to a psychiatric hospital and 30% had been diagnosed with a psychiatric illness.

Thirty – five per cent (35%) of people who are homeless in Northern Ireland have been diagnosed with mental illness according to the Health Promotion Agency in 2002.

A study by the Office of National Statistics of people who are homeless in Glasgow (Kershaw, Singleton and Meltzer, 2000) found that 73% had experienced one or more neurotic symptoms in the past week and 44% were assessed as having a neurotic disorder.

As one can see, the level of diagnosed mental health conditions among people who use Simon projects and services is high, even when compared with other research findings focusing on people experiencing more extreme forms of homelessness.

Undiagnosed Mental Health Conditions

This snapshot study also recorded undiagnosed mental health observations. A total of 350 people who use Simon projects and services or 44% of the total have at least one undiagnosed mental health condition. Respondents were able to identify up to 2 undiagnosed mental health issues. The most common mental health observations are anxiety disorders (16%) and mood disorders (11%).

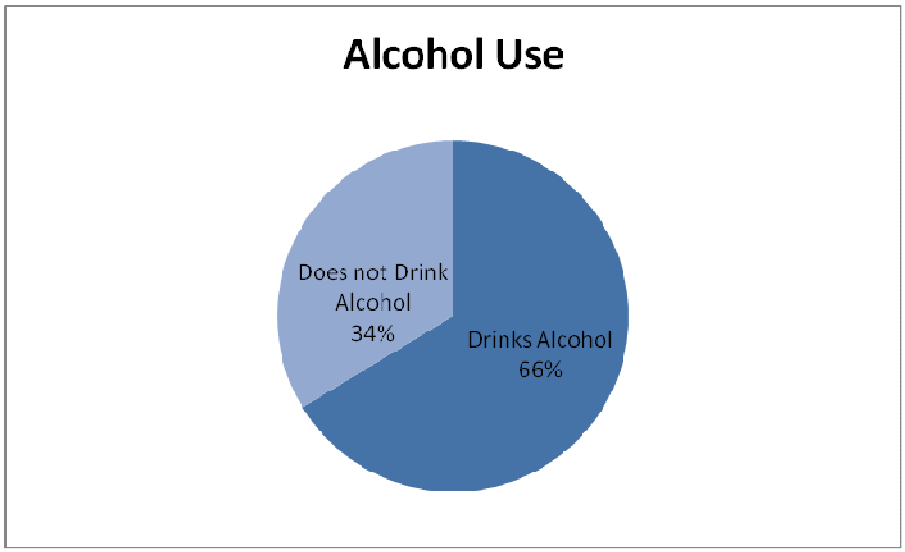
Numbers of Undiagnosed Mental Health Conditions Observed							
Health Condition	No.	Health Condition	No.	Health Condition	No.	Health Condition	No.
None	438	Developmental Disorders	16	Mental Decline	29	Personality Disorders	28
Anxiety Disorders	123	Eating Disorders	29	Mood Disorders	87	Psychotic Disorders	158

A clear picture emerges from the examination of diagnosed and undiagnosed mental health among people who use Simon projects and services of very high levels of mental illness. It is also common for people

who are homeless to have several psychiatric problems at once. Some of the mental health conditions that are significantly high among users of Simon projects and services are schizophrenia, personality disorders and depression. Even where there is no diagnosed mental health condition there is a clear evidence of a lack of mental wellbeing among most people who use Simon projects and services.

3.15 Alcohol Use

The research employed a simple 'yes' or 'no' questionnaire asking people who use Simon projects and services whether they use alcohol. As stated this was not a prevalence study and it did not assess quantities or frequencies. Of the 769 people who answered this question (19 unknowns) 510 people or 66% use alcohol while 259 (34%) do not.



Homeless research generally identifies high levels of problematic drug and alcohol use among people who are homeless. Research generally points to a greater proportion of people sleeping rough being alcohol reliant or using alcohol problematically (Crisis, 2003)[7].

Aside from dependency, problem alcohol use brings a range of serious secondary illnesses, such as hepatitis, alcoholic cirrhosis, memory loss and seizures. Those dependent on alcohol are also substantially more likely to die from unnatural causes related to drug or alcohol poisoning than the general population (FEANTSA, 2006).

[7] In this context it is worth noting that homeless research generally concentrates on people at the more emergency end of homelessness. The small rough sleeping component in this sample of Simon service users needs to be taken into account when drawing conclusions here.

Complications arising from alcohol use

The questionnaire also asked about the extent of complications arising from alcohol use. A total of 232 people using alcohol were identified as having some complications arising from alcohol use. This represents 30% of those who participated in the study (769 respondents, 19 unknowns). Fifty – five per cent (55%) of people who use alcohol acknowledged that they had complications arising from use.

The nature of the complications arising is set out in the table below. Respondents were able to specify up to 2 complications.

Complications arising from alcohol use					
Complication	**Number of Respondents**	**Complication**	**Number of Respondents**	**Complication**	**Number of Respondents**
Those who use alcohol who have no complications[8]	278	Falls/Head Injuries	84	Liver Failure	1
Diagnosed Cirrhosis	9	Gastric Problems	51	Memory Loss	94
Epilepsy	9	Liver Damage	63	Seizures	25

This overview shows that memory loss as well as falls/head injuries are the most common complications arising from alcohol use. This is followed by liver damage and gastric problems.

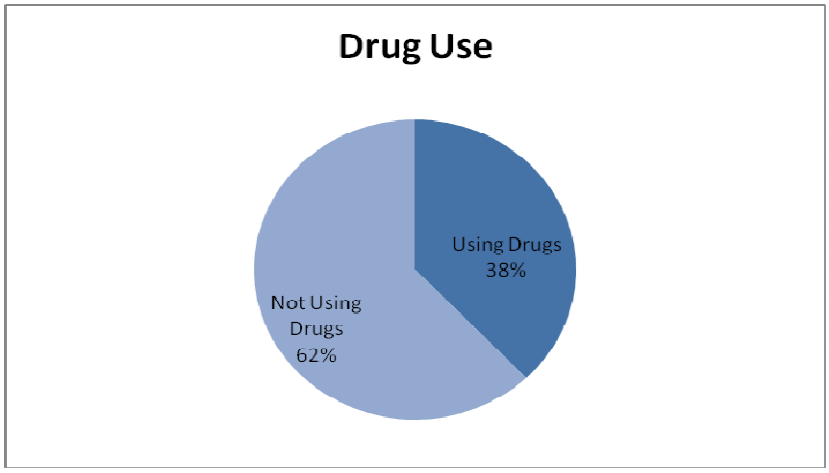
Comparison

These findings are similar to the NACD study of 2005 which reported that among respondents alcohol was the primary drug of choice, being used by 70%. The low proportion of people who are rough sleeping in the Simon sample should be taken into account as this affects the results regarding health status and alcohol and drug use. For example the NACD 2005 study found that those staying in squats and sleeping rough reported a high frequency of alcohol consumption in terms of use in excess of 4 times a week. Fifty two percent (52%) of people sleeping rough recorded in the NACD study were identified as problematic alcohol users. It should be noted, however, that respondents in the Simon sample indicated personal alcohol use as one of the main reasons for their homelessness (19%).

3.16 Drug Use

The questionnaire also asked about drug use other than alcohol. Of the people who answered this question, 291 (38%) were using drugs and 477 (62%) were not (20 unknown). The findings here support the hypothesis that the extent of drug use among people who are homeless is high.

[8] 5 people who had formerly used alcohol and who were no longer using alcohol indicated they had some complications arising from their previous alcohol use.



Heroin is the most common drug used by 21% of all people who use Simon projects and services who answered this question. This represents 55% of all of those who use drugs in this sample. The use of heroin is highest in the Dublin Area and it is also commonly used in Cork, with lower frequency in other areas. Cannabis is the second most common drug, used by 15% of all respondents who answered this question. This represents 40% of those who use drugs.

Benzodiazepine is the third most common drug, used by 12% of all people who use Simon projects and services, which represents 32% of those who use drugs. This is followed by Head Shop substances which are used by 7%, representing 19% of those who use drugs. Methadone is the fifth most common drug, used by 7% of all people who use Simon projects and services who answered this question and 18% of those who use drugs. In addition, 102 survey participants were identified as being prescribed methadone. The difference between the numbers on methadone use and methadone prescription may be due to some interviewees (and the interviewer) assuming that the questions on drug use relate only to illicit drug use. This could also indicate that some people in the sample were using illegal methadone i.e. purchasing methadone on the street that is not prescribed for their use. In addition, cocaine is used by 17 respondents and 24 respondents reported use of other drugs.

Drugs most commonly used	
Drug Type	Number of Respondents
Benzodiazepine	94
Cannabis	116
Cocaine	17
Head Shop Substances	54
Heroin	159
Methadone	53
Other	24
Unknown	13

Poly Drug Use

Ninety one snapshot study participants (12% of all respondents and 31% of all respondents using drugs) were using two drugs at the same time and 73 (10% of all respondents and 25% of all respondents using drugs) were using three drugs. The research participants were able to identify a maximum of 3 drugs used. This has obvious implications in terms of risks, harms and health consequences.

IV Drug Use

One hundred and fifteen people who use Simon projects and services were using drugs intravenously. Eighty one of these were using Dublin Simon projects and services. These 115 people represent 15% of all people who use Simon projects and services who answered this question and 40% of all people who use Simon projects and services who use drugs.

Complications arising from IV drug use

Drug use, particularly intravenous drug use, carries many secondary risks. People who are using drugs are vulnerable to transmission of serious infectious illnesses, such as hepatitis and HIV through the sharing of syringes. Poor injecting techniques and other easily corrected drug using behaviour means people are also vulnerable to large numbers of minor infections, which when untreated can have ongoing health consequences. Of the 115 people who were using drugs intravenously the following ccomplications arising from IV drug use were identified (respondents were able to give up to two complications).

Complications arising from drug use	
Type of Complication	**Number of Respondents**
HIV	8
Abscesses	25
DVT (Deep Vein Thrombosis)	13
Endocarditis	2
Hep B and/or Hep C	41
Over Dose	11
Septicaemia	2
Vein Damage	39

The table shows that 41 respondents indicated Hepatitis B and/or C as one of the complications related to their drug use. This is followed by 39 people who indicated vein damage as a complication and 25 people who reported suffering from abscesses linked to their drug use. A total of 8 people reported acquiring HIV as a result of their drug use.

Viral Screening

Respondents were also asked whether they had ever had a viral screening to check for any transmittable diseases. Seventy eight of all respondents to the questionnaire have had a viral screening; 68 of those who were living in Dublin.

Comparisons

This health study does not look at problematic drug use per se, so it is difficult to make direct comparisons with other research studies such as the NACD study, which examined this issue in depth. However the information in this study is indicative. The NACD 2005 study found higher levels of drug taking in its sample population. As mentioned this may be explained by the fact that the research targeted emergency settings rather than the wide range of services covered in the Simon sample. Over a third of respondents (36%) in the NACD study reported problematic drug use with a much higher proportion of problematic drug users within Dublin compared to outside Dublin (43% v 19%). This supports similar findings in this study, where 70% of the people using drugs intravenously were in Dublin. This would be supported in most drug use studies with prevalence of IV drug use being highest in large urban settings for a number of reasons, including access to drug markets and the concentration of services, especially needle exchange. (The only needle exchange service in Ireland open on a daily basis is in Dublin city centre and only opens Mon-Fri.)

In the NACD study cannabis was the primary illicit drug of current use among the survey participants (43%), 22% were using heroin. Over a third of the total study population reported having ever injected (35%) increasing to almost half within the Dublin sample (46%). The NACD report found that changes in drug using patterns, generally negative in nature, occur as a result of becoming homeless. Over three in- four people currently using drugs (77%) reported having changed their drug using pattern after becoming homeless. Initiation into drug use (for a minority), changes in primary drug and routes of administration e.g. changing from smoking to injecting, increased frequency/quantity, and increased risk behaviour were all cited.

In terms of illicit drug use by accommodation type, the NACD report also found that the highest percentage of illicit use (73%) was among people sleeping rough, in comparison with those staying in B&B accommodation or hostels (67% and 43% respectively). This high level of illicit drug use among people sleeping rough was consistent across both Dublin and non-Dublin samples.

In Northern Ireland more than two thirds of people who are homeless have used drugs at some stage in their life with current drug use at levels 10 times greater among people who are homeless than observed for the general population (Health Promotion Research Board, 2003). This Simon snapshot study did not investigate previous or lifetime drug use.

3.17 Complex Needs

A comprehensive definition of 'complex needs' is offered by the UK organisation Turning Point defines complex need as:

"*…a framework for understanding multiple interlocking needs that span health and social issues. People with complex needs may have to negotiate a number of different issues in their life, for example learning disability, mental health problems, substance abuse. They may also be living in deprived circumstances and lack access to stable housing or meaningful daily activity. As this framework suggests, there is no generic complex needs case. Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalised response from services*" (Rankin and Regan, 2004).

As this definition highlights, the area of complex needs is multi-faceted and goes beyond the area of health and problematic alcohol and drug use. However, as the focus of this snapshot study is on the health needs of people who are homeless, complex needs in this section are discussed under two headings:

- People who have both diagnosed physical and mental health conditions
- People with a suspected dual diagnosis, i.e. people who have a diagnosed mental health condition and report complications arising from their alcohol and/or drug use

Both Diagnosed Physical and Mental Health Conditions

In total 221 respondents, 28% of all people interviewed, had at least one diagnosed physical and at least one diagnosed mental health conditions. This varies by Community peaking at 52% in Galway Simon Community. The information is set out in the table below for each Community:

Number with both diagnosed conditions by Community

Community	Number with Both Diagnosed Conditions	%
Cork	37	20%
Dublin	83	24%
Dundalk	1	6%
Galway	48	52%
Midlands	17	36%
Midwest Simon	2	22%
North West Simon	30	38%
South East Simon	3	50%
Total	221	28%

The level of both diagnosed physical and mental health conditions among people who use Simon projects and services is significant and implies complex support needs for this group of people who are homeless. Please note that these percentages above do not include undiagnosed physical conditions with 36% of the study participants reporting at least one undiagnosed physical health condition and 44% of study participants reporting at least one undiagnosed mental health condition.

Dual Diagnosis

Two hundred and eleven respondents, 28% of all people interviewed, were diagnosed with a mental health condition and reported complications arising from their alcohol and/or drug use. The information is set out under each Community in the table below:

Number with suspected dual diagnosis by Community

Community	Number with both diagnosed conditions	%
Cork	49	26%
Dublin	92	26%
Dundalk	3	18%
Galway	37	40%
Midlands	11	36%
Midwest Simon	1	11%
North West Simon	16	20%
South East Simon	2	33%
Total	**221**	**28%**

This 28% of people using Simon projects and services, who have a diagnosed mental illness and either use drugs or alcohol with complications, indicates with a strong probability, the presence of a dual diagnosis complaint. It is important to highlight that this only includes diagnosed mental health conditions, if one were to add people who reported at least one undiagnosed mental health condition in these percentages would be higher.

3.12 Accessing Medical Services

Medical Card Holders

To qualify for a medical card the weekly income must be below €184 for a single person and €266.50 for a cohabiting couple. A means test is carried out to assess income level and if any assets are owned by the applicant. The overwhelming majority of survey participants (84%) were medical card holders. This represents a total number of 657 with 131 respondents (16%) not holding a medical card at the time of the survey (with 9 unknowns).

Comparison

Respondents in the NACD 2005 study were also asked if they had a current medical card. Sixty-two per cent reported being holders of a current medical card. This is much lower than the present level of medical card access in the Simon sample and suggests that the system of localising medical card distribution has had a positive impact in improving access to medical cards for people who are homeless. This system has recently (summer 2010) been centralised. The impact of this in relation to medical card access for vulnerable groups, such as people who are homeless, remains to be seen.

Registered with a GP

Seven hundred and nine people were registered (90.5%) with a GP (with 5 unknowns). A total of 84 people (or 9.5%) using Simon projects and services were not registered with a GP. Of this total of 84 people, 37 were using Cork Simon projects and services and 42 were using Dublin Simon projects and services. This is a very high rate of registration and is a positive outcome of the proactive efforts amongst Simon Community staff's in supporting people in accessing their medical entitlements.

Number of Presentations to A&E in Last Month

One hundred and nineteen people who use Simon projects and services or 16% of all respondents who answered this question (756 people – 32 unknowns) attended A & E hospital in the last Month.

- 77 respondents or 10% attended A&E once over the last month
- 23 respondents or 3% attended A&E twice over the last month
- 9 respondents or 1% attended A&E three times over the last month
- 5 respondents or 1% attended A&E four times over the last month
- 5 respondents or 1% attended A&E five or more times over the last month.

Number of Presentations as Out-Patient to Hospital in Last Month

One hundred and fifty – four people who use Simon projects and services or 20% of all respondents who answered this question (759 people – 29 unknowns) attended hospital as an "out-patient" in the last Month.

- 86 respondents or 11% attended as an out-patient once over the last month
- 19 respondents or 3% attended as an out-patient twice over the last month
- 6 respondents or 1% attended as an out-patient three times over the last month
- 7 respondents or 1% attended as an out-patient four times over the last month
- 7 respondents or 1% attended as an out-patient five or more times over the last month.

Number of Presentations as In-Patient to Hospital in Last Month

64 people who use Simon projects and services or 8% of all respondents who answered this question (758 people – 30 unknowns) attended hospital as an "in-patient" in the last Month.

- 56 respondents or 11% attended as an in-patient once over the last month
- 6 respondents or 3% attended as an in-patient twice over the last month
- 1 respondents or 1% attended as an in-patient four times over the last month
- 1 respondents or 1% attended as an in-patient five or more times over the last month

These findings indicate that the health care needs of some people in this snapshot study were/are not being met in existing primary care settings and this warrants further exploration and intervention. The "continuum of care" approach that homeless services aspire to and people who are homeless require is not the remit of A&E departments. In addition, A&E departments generally do not have specialist training in dealing with people with complex needs. Finally, the costs to the State associated with attendance at A&E and other hospital services are significantly higher compared to more appropriate primary care support where possible. Recommendations in relation to facilitating a reduction in use of A&E services by people who are homeless are contained in Section 4 of this report.

3.13 Challenging Behaviour

This snapshot study also looked at issues in relation to challenging behavior. Survey participants were asked whether they considered themselves to be aggressive, violent or withdrawn or none of the above. In some cases, the staff of Simon projects and services also drew conclusions on the participants' behavior.

The interviews and review of records found the following:

Challenging Behavior		
Behavioural Issue	**Number of Respondents**	**%**
Aggressive	131	17%
Violent	33	4%
Withdrawn	102	13%
Unknown	20	3%
No behavioural issues	502	65%

The vast majority of people using Simon projects and services have no behavioural issues (65%). There are, however, a significant proportion of people who can be described as demonstrating behaviour issues

(34%). Of these (17%) can be described as being aggressive with a very small proportion of people being described as violent (4%). Thirteen per cent (13%) of the snapshot study participants are described as being withdrawn. These findings indicate that a minority of people who are homeless may channel the significant stress linked to the experience of homelessness through different forms of challenging behaviour. This finding must also be viewed in the context of the next section that looks at levels of self-harm and suicide amongst of people interviewed for this study.

3.14 Self Harm and Suicide

It is well documented that mental health conditions lead to a higher risk of suicide and self-harm. The considerable stress linked to the experience of homelessness must also be viewed as a contributing factor to high levels of self-harm amongst people who are homeless.

Of participants in this study:

- One hundred and nine (15%) of respondents are presently self harming (6 unknown).
- One hundred and sixty – four (23%) have some recurring ideas about committing suicide; known as suicide ideation (88 unknowns).
- Fifty six people (8%) have attempted to commit suicide in the last 6 months (75 unknowns).

Comparison

Comparison can be made with a US study (Prigerson et al, 2003) which conducted interviews in a multi-site outreach programme focused on people who are homeless with mental health issues. The research asked respondents whether they had serious suicidal ideation and or attempted suicide in the last 30 days. The prevalence of 30-day suicidal ideation and suicide attempts (37.5 % and 7.9 %, respectively) was higher than the Simon sample above. However, contrary to the Simon sample, the US study focused entirely on people who were diagnosed with a mental illness and were homeless. The rate of suicide attempt varied with the age and the existance of probelmatic drug use and/or alcohol use amongst this sample.

4. Conclusion and Recommendations

People who are homeless often have multiple and severe health conditions, including physical as well as mental health issues. In addition, many people who are homeless are problematic drug and alcohol users and a significant number of people suffer from dual diagnosis. These findings of this snapshot study demonstrate that the issues experienced by people who are homeless are far broader than a lack of accommodation but are closely interrelated with a range of complex needs, including but not limited to health needs. The availability of appropriate and accessible care and health support for people who are homeless is therefore a crucial element of any strategy which aims to tackle homelessness in a sustainable way.

The need to provide adequate and holistic health support for people who are homeless is acknowledged in the Government's National Homeless Strategy *A Way Home: A Strategy to Address Adult Homelessness in Ireland 2008-2013* (2008). There are, however, a range of outstanding issues that are mainly linked to the full implementation of the Strategy's Implementation Plan. In particular, there is still a need for greater interagency cooperation, inter disciplinary working, and interface across the different responsible Government departments to address the sometimes complex needs of people who are homeless.

The following section presents the conclusions and recommendations related to this snapshot study.

4.1 Improving access to health care for people with complex needs

Conclusion

People who are homeless face significant difficulties in accessing appropriate health care due to administrative and financial barriers. In addition, the mainstream health system is not always fully equipped to deal with people who are homeless and the issues with which they present.

The HSE has responded by establishing multidisciplinary primary health care teams in Dublin, Cork, Limerick and Waterford and by funding homeless services to employ nurses and drug and alcohol counsellors, among other measures. However there is still a need for better cooperation between the HSE and homeless services.

Recommendations

- Homeless services and the relevant HSE personnel should work more closely together to support the development of better cooperation between homeless and health services including mental health services so that "[E]everybody will have easy access to high quality care and services that they have confidence in and that staff are proud to provide[9].

[9] HSE commitment as part of its Transformation Programme

- Homeless services need multi annual financial support in order to employ health care professionals to work directly with people who are homeless in the homeless services.

- Specialist services working in conjunction with mainstream services are proven to be effective when working with people who are homeless and supporting them to manage and overcome their combination of health problems. Existing specialist services working with people who are homeless must be maintained, such services must be expanded into areas where they are required.

4.2 Improving access to drug and alcohol services for drug /alcohol users who are homeless

Conclusion

Health services have not adapted fast enough to the changing pattern of drug and alcohol use among people who are homeless (O'Carroll, 2008). This report identifies IV drug use and alcohol and/or drug use with complications among people who are homeless who are living outside of urban areas where there are very limited drug related support services.

A high level of mental illness alongside problematic alcohol and drug use by people who are homeless is also recorded in this research with indications that up to 28% of survey participants may have a "dual diagnosis".

Recommendations

- Accessible needle exchanges, fast access to substitution treatment including methadone, safe injecting facilities (SIF's) and hepatitis B immunization all need to be more accessible for drug users who are homeless including in areas outside of urban centers.

- The provision of a specialist and accessible alcohol detoxification and rehabilitation services for homeless drug and alcohol users outside of urban centers.

- The provision of a greater number of drug counselors based on both on an abstinence and harm reduction models.

- Drug and alcohol services and mental health services must become better equipped to work together with those presenting with dual diagnosis.

4.3 Improving access to homeless services for drug and alcohol users.

Conclusion

Alcohol and drug use are sometimes reasons for exclusion from some homeless services (FEANTSA, 2006). Research internationally argues that being alcohol or drug free should not be a condition of access to homeless services, as there is a risk of further excluding people from the very last forms of low threshold health and social care available to them. For problematic drug and alcohol users abstinence may be unacceptable as a goal and in such cases, it is necessary to implement strategies which focus on moderation in use and reducing drug and alcohol-related risk and harm.

Recommendation

- There is a need for more low-threshold services among homeless services in Ireland. This includes more flexibility in relation to access policies and the adoption of harm reduction strategies by homeless services. In these services, people who are homeless should be given the opportunity and support to access the relevant treatment that will support their move out of homelessness.

4.4 Reducing Accident & Emergency usage, and hospital and prison stays

Conclusion

There is a specific group of people who are homeless with multiple needs, they make up about a third of people who use Simon projects and services[10]. This group stays more frequently and for longer periods in hospital. While A&E as well as prison services are very costly services, they are not always equipped to cater for the needs, including health needs, of people who are homeless. Research indicates that the availability of more appropriate services to people who are homeless will reduce the use of A&E and prisons, which may help to decrease overall cost (Culhane, 2008).

Recommendation

- Notwithstanding limited public resources, investment in appropriate supported care and accommodation settings for people who are homeless, irrespective of where a person presents as homeless, should be maintained and future provision should be planned for and resourced. Such investment will reduce the amount of A& E usage and in-hospital attendances and prison and other institutional stays and should translate into cost savings overall.

[10] 28% of people using Simon services and projects have both a diagnosed physical and mental health condition with indications that up to 28% of people may have a "dual diagnosis".

4.5 Ending inappropriate discharge practices

Conclusion

Even though a number of strategies on prevention of homelessness have highlighted the issue, unacceptable discharge practices from e.g. general and psychiatric hospitals continue in Ireland. Individuals are discharged into the care of homeless services that are simply not equipped to meet their needs. Hostels and shelters may not be the best environment for recuperating patients.

Recommendation

- Government and homeless services should work to fill the gap in the care system for people who are homeless who are not ill enough to be hospitalised, but who need bed-rest and care in order to recover. This should be in the form of a safe and secure respite care setting where accommodation and support are combined to allow people to recuperate fully and build on the break from sleeping rough or an emergency accommodation environment which they were in previous to their hospital admission.

4.6 Achieving Standardised Needs Assessment

Conclusion

Different health assessment and admission procedures are used in many parts of Ireland when homeless services and statutory agencies assess the needs of the people using their services. In Dublin a Holistic Needs Assessment and a separate Care and Case Management Approach has been piloted by the Homeless Agency to help facilitate the sharing of information and joint working.

Recommendation

- The Homeless Agency Care and Case Management pilot project, if is adjudged a success, should be rolled out to all parts of the country.

4.7 Training Front Line staff

Conclusion

In the light of the findings in this research of high levels of morbidity amongst survey participants across the spectrum of homelessness, including people at risk of homelessness and people now settled in long term accommodation, there may be need for further training for homeless service front line staff on physical and mental health promotion and issues related to problematic alcohol and drug use.

Recommendation

- Homeless services where a training deficit is identified should, supported by the HSE, invest in training for front line staff on health promotion, harm reduction and issues related to problematic drug and alcohol use. The training should be designed to give front line staff the skills to identify health needs of people, to provide adequate health support to people who are homeless, and to make appropriate referrals.

4.8 Access to services for those affected by Habitual Residence Condition (HRC)

Conclusion

The HRC is a cross cutting issue involving the Department of Social and Family Affairs in conjunction with the Department of Justice, Equality and Law Reform and the Department of Environment, Heritage and Local Government. Confusion as to how the Condition should be interpreted has left homeless services uncertain as to whether they are allowed offer services to people who are homeless affected by the HRC, with differing messages coming from various Government departments. Almost 7% of people who use Simon projects and services are affected by the Habitual Residence Condition (HRC). The numbers of people affected by the Condition who are homeless is likely to be higher than 7% nationally for a variety of reasons.

Recommendations

- The Department of the Environment, Heritage and Local Government should work with other Government Departments to agree a protocol whereby those who are homeless affected by the HRC are not denied access to the basics of living supports, such as emergency accommodation. The Department should circulate clear guidance to homeless services that they can accommodate people affected by the HRC, without this impacting negatively on their funding.

- Review of the impact of the HRC.

4.9 Further research to focus on pathways out of homelessness

Conclusion

Research explanations of homelessness are in part explained by the unit of observation. This report has an almost exclusive focus on the personal factors why people become homeless and the health and other issues of people who use Simon projects and services at a specific point-in time. This research should be complemented by research looking at other causal factors of homelessness as well as research into effective preventative strategies.

Recommendation

- Consider research on a national level into other causal factor of homelessness such as educational attainment, access to employment and training as well as the protective factors which prevent homelessness from occurring in the first place. In future years, invest into research which tracks people's routes out of homelessness and use this learning to help enhance homeless services capacity to support people in moving out of homelessness as quickly as possible.

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