Simon Snapshot Report
2011

2011

Kathy Walsh

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1 Introduction

1.1 Simon Communities in 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, we tackle the root causes, promote innovative responses and urge 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 terms of 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.

1.2 A definition of Homelessness

The 1988 Housing Act defines a homeless person as somebody who has no reasonable accommodation to live in or lives in a hospital, institution or night shelter because of a lack of home. This definition while widely used is not without its critics who believe it is too narrowly focused. A more inclusive definition developed by the European Federation of National Organisations working with the homeless (FEANTSA) define homelessness as 'the absence of a personal, permanent, adequate dwelling. FEANTSA have a typology of homelessness and housing exclusion based on the conceptual understanding that there are three domains which constitute a "home". The typology classifies people who are homeless according to their living situation:

- *rooflessness* (without a shelter of any kind, sleeping rough)
- *houselessness* (with a place to sleep but temporary in institutions or shelter)
- living in *insecure housing* (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence)
- living in *inadequate housing* (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

See Table 1 for details of the FEANTSA ETHOS Typology

1.3 Factors that contribute to homelessness

Many factors contribute to homelessness including poverty, poor educational achievement, poor quality jobs or unemployment, high cost of buying or renting a home, difficult relationships at home, leaving institutional care, inadequate community support services, ill-health - including physical and mental health - physical, sexual and mental abuse, disability, problematic drug and/or alcohol use, crime, and leaving prison. For many people it can be a combination of these factors, some of which can be linked to structural inequalities while others are more related to the circumstances of a particular person.

Table 1.1 FEANTSA ETHOS Typology of Homelessness

Conceptual Category		Operational Category		Living Situation		Generic Definition
Conceptual Category	ROOFLESS	1	People Living Rough	1.1	Public space or external space	Living in the streets or public spaces, without a shelter that can be defined as living quarters
		2	People in emergency accommodation	2.1	Night shelter	People with no usual place of residence who make use of overnight shelter, low threshold shelter
	HOUSELESS	3	People in accommodation for the homeless	3.1	Homeless hostel	Where the period of stay is intended to be short term
				3.2	Temporary Accommodation	
				3.3	Transitional supported accommodation	
		4	People in Women's Shelter	4.1	Women's shelter accommodation	Women accommodated due to experience of domestic violence and where the period of stay is intended to be short term
		5	People in accommodation for immigrants	5.1	Temporary accommodation / reception centres	Immigrants in reception or short term accommodation due to their immigrant status
				5.2	Migrant workers accommodation	
		6	People due to be released from institutions	6.1	Penal institutions	No housing available prior to release
				6.2	Medical institutions (*)	Stay longer than needed due to lack of housing
				6.3	Children's institutions / homes	No housing identified (e.g by 18th birthday)
		7	People receiving longer-term support (due to homelessness)	7.1	Residential care for older homeless people	Long stay accommodation with care for formerly homeless people (normally more than one year)
				7.2	Supported accommodation for formerly homeless people	
	INSECURE	8	People living in insecure accommodation	8.1	Temporarily with family/friends	Living in conventional housing but not the usual or place of residence due to lack of housing
				8.2	No legal (sub)tenancy	Occupation of dwelling with no legal tenancy illegal occupation of a dwelling
				8.3	Illegal occupation of land	Occupation of land with no legal rights
		9	People living under threat of eviction	9.1	Legal orders enforced (rented)	Where orders for eviction are operative
				9.2	Re-possession orders (owned)	Where mortagee has legal order to re-possess
		10	People living under threat of violence	10.1	Police recorded incidents	Where police action is taken to ensure place of safety for victims of domestic violence
	INADEQUATE	11	People living in temporary / non-conventional structures	11.1	Mobile homes	Not intended as place of usual residence
				11.2	Non-conventional building	Makeshift shelter, shack or shanty
				11.3	Temporary structure	Semi-permanent structure hut or cabin
		12	People living in unfit housing	12.1	Occupied dwellings unfit for habitation	Defined as unfit for habitation by national legislation or building regulations
		13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding	Defined as exceeding national density standard for floor-space or useable rooms

Note: Short stay is defined as normally less than one year; Long stay is defined as more than one year.
This definition is compatible with Census definitions as recommended by the UNECE/EUROSTAT report (2006)

(*) Includes drug rehabilitation institutions, psychiatric hospitals etc.

The Simon Communities are particularly aware of the strong relationship between homelessness and health given that a person's home (or the absence of it) plays a central role in shaping their physical health and their feelings of wellbeing and general ability to cope with everyday life. The relationship between health and homelessness is a complex one in that[1].

- health problems can cause a person to become homeless (e.g.: poor physical or mental health can reduce a person's ability to find sustainable employment)

[1] US Institute of Medicine (1988) Homelessness, Health and Human Needs.

-some health problems (e.g. depression, poor nutrition, problematic drug and alcohol use) are the consequences of homelessness.

-being homeless can exacerbate and complicate the treatment of many health problems, given that people who are homeless have significantly less access to health services than the broader population.

Research[2] has indeed found that people who are homeless have higher than average mortality rates linked to higher levels of physical and mental illness and problematic drug and/or alcohol use, inadequate access to health care and often severe poverty.

1.4 National policy responses to homelessness

The Way Home, the National Strategy to address Adult Homelessness in Ireland (2008 – 2013) has three core objectives:

- eliminating long-term occupation of emergency homeless facilities;
- eliminating the need to sleep rough; and
- preventing the occurrence of homelessness as far as possible.

Local authorities also have Homeless Action Plans which vary from authority to authority. These Plans are important in that they acknowledge the need for health and social facilities for homeless people but they lack the specific proposals required for their development.

The 2009 Housing Act put Homelessness Action Plans and Homelessness Fora on a statutory basis to be implemented at both regional and local level. The purpose of the regional Homelessness Fora is, to provide information, views, advice or reports in relation to homelessness and in relation to the provisions of the draft homelessness action plans and the operation and implementation of the action plans.

Other polices which have an impact on homelessness include the National Health Strategy and the interim National Drugs Strategy in place until the publication of the national substance misuse strategy and "Vision for Change" The National Mental Health Strategy. The National Health Strategy identifies a number of initiatives to improve the health and well-being of people who are homeless that include elements of Homelessness – an Integrated Strategy (2000) and the Youth Homelessness Strategy (2001) as well as the provision of medical cards for people who are homeless.

The (interim) National Drugs Strategy 2009-2016 identifies the fact that a significant number of people who are homeless require access to treatment and rehabilitation services and reports increases in expenditure on homeless services specifically in relation to accommodation and on support services generally. The Strategy recognises that gaps in services persist, particularly in regard to attracting (and retaining) drug users with complex needs who are homeless into treatment. The Strategy also makes specific reference to the problems associated with people who present with dual diagnosis (i.e mental health and problematic drug and /or alcohol use).

One of the central principles of a "Vision for Change" the National Mental Health Strategy is that mental health services should be provided for an individual in the catchment area in which they normally reside. This presents difficulties, when people become homeless and

[2] Holohan, T. (1997) Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin. Eastern Health Board

move, often drifting into the city areas. For this reason, and because the largest proportion of people who are homeless are in Dublin, the Strategy proposed the establishment of two multidisciplinary, community-based teams for the Dublin area.

1.5 The Study Aims and Objectives

The aim of this research is to enhance understanding of the multiple health needs of people who are homeless/at risk of homelessness.

The objectives of the study are to:

- Capture the multiple health needs of people using Simon services who are homeless/at risk of homelessness
- Analyse and document these needs
- Draw conclusions on the health and other related services required to meet the health needs of people who are homeless.

The information collected will be used both publicly and privately for campaigning and lobbying purposes.

1.6 The Report Content & Structure

The report is structured into four key sections. Section 1 and 2 are the introduction and methodology sections respectively. Section 3 details the main findings of the snapshot study while Section 4 details the recommendations arising from the study.

2 Methodology

2.1 The Survey

This snapshot study was conducted using a survey administered during the week of the 4th – 11th July 2011 by staff at the eight local Simon Communities around Ireland (with the support of Simon National Office). This nature of the survey conducted, as it was over a single week, provides a 'point in time' snaphot of health needs of people using Simon services, in this case one week. While it does not provide an overall picture of the profile and health needs of all people who use Simon Services it does provide a significant sample at a 'point in time' and can be used to generalise about the health and support needs of people who access the service and projects of the Simon Communities around the country.

2.2 The Questionnaire

The questionnaire was originally developed in 2010 based on work undertaken by Cork and Dublin Simon Communities in 2009. It was further refined in 2011 based on an analysis of the learning arising from the administration of the 2010 survey. The adjusted questionnaire was administered by seven of the local communities while the Cork Simon Community chose to use a modified version of the 2011 questionnaire. The survey was administered to three different groups of people:

- 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.

2.3 The total population and the sample

The recently published 2011 Assessment of Housing Need[3] identified 98,318 households in need of social housing support. 2,348 households were specifically identified as homeless as part of the assessment. These figures contrast sharply with the previous 2008 Assessment of Need which identified only 1,394 households that were homeless.

The differences in the 2011 and 2008 figures can largely be seen to relate to changes in the methodology used to collect the 2011 data. Notwithstanding the significant increase in the number of households identified as homeless between the 2008 and 2011 assessments, the 2011 housing assessment figures for homelessness continue to raise questions given that the 2008 Homeless Agency 'Counted In' survey of homelessness found 2,144 households using homeless services in the Dublin region alone , while similar 'Counted In' studies in Cork, Limerick and Galway cities in 2008 found 767 households that were homeless.

The discrepancy between the Housing Need Assessment figures and the 'Counted In' figures and experiences of other bodies and organisations that are seeing a growing demand for services can be seen to stem back to the way homelessness is defined. Official statistics exclude certain groups of people e.g. people using emergency accommodation or other services. It is also the case that people who are homeless move from place to place or indeed move in and out of homelessness making it difficult to get an accurate count of the total homeless population[4].

There are ongoing problems with the homeless counts due to definitional and methodological difficulties. 'Counted In' counts the number of persons using homeless services at a particular time in a particular place. The Housing Needs Assessment only includes people who are deemed to be in need of local authority housing at the exact time the survey is conducted. Thereby excluding those not on the local authority lists and people in transitional housing, residential supported units etc. In addition such counts often only count those in contact with services and supports with many others living in inappropriate, unfit or insecure accommodation going unreported.

This research 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.

The application and use of convenience sampling saw the Simon Communities sample people who had accessed supports from them during the week of the 4th – 11th July 2011.

[3] Housing Agency (2011) Housing Needs Assessment 2011, Dublin
[4] http://www.focusireland.ie/index.php/press-release-archive/2009/210-17th-august-2009housing-needs-assessment-underestimates-homelessness

Some of the people accessing Simon Services that week were invited to participate in the survey and the majority were happy to do so.

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. One of the communities (Simon South East) requested additional support from the researcher but otherwise the questionnaires were completed by the Communities themselves who oversaw the process of interviews. Consent was negotiated locally by each individual Community.

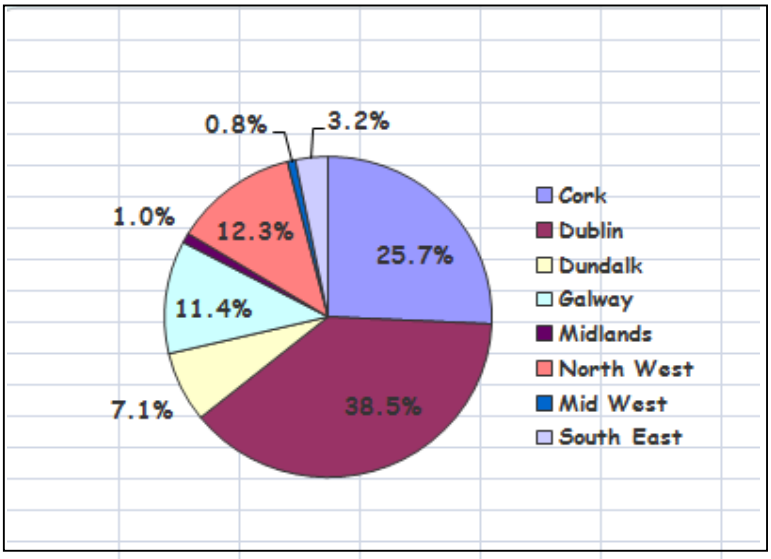
The survey was generally administered by Simon staff across the eight local communities at venues convenient to the survey participants. Venues used included Simon day centres; emergency, transitional, supported and long-term housing; outreach and tenancy sustainment services. A total of 603 people participated in the 2011 survey. See Table 2.1 for a breakdown of the questionnaires completed by Community

Table 2.1 A breakdown of Questionnaires completed

Region	*No. in 2011*	*% of 2011 Total*
Cork	155	26
Dublin	232	39
Dundalk	43	7
Galway	69	11
Midlands	6	1
Mid West	5	1
North West	74	12
South East	19	3
Total	603	100

In general, the more urban and longer established Simon Communities, which tend to be in contact with a greater number of people, not surprisingly returned the larger numbers of questionnaires. See Figure 2.1 for a pictorial representation of the survey responses by Community. It is important to note that the people who participated in the study represented a sample of those using Simon projects and services. They do not reflect or represent the total number of people using Simon projects and services around the country during the week of the survey for a number of reasons. For example some people who accessed services did not wish to participate in the research, in other cases local Simon Communities lacked the time and human resources necessary to conduct the research. There were also issues related to the sheer scale of the numbers using Simon projects and services. The Simon Communities collectively work with 4,500 to 5,000 people every year.

Figure 2.1 Survey Responses by Community



Once the survey period was over, data was returned either in the form of paper questionnaires (to be inputted by the researchers) or returned as completed excel sheets to be merged with the other data. Some difficulties arose in relation to data corruption which meant that this process was more drawn out and complicated that had originally been anticipated.

2.4 Survey Limitations

All questionnaires have to strike a balance between the length of time required to complete the questionnaire and the nature and extent of questions to be explored. This inevitably involves some compromises. In the case of the Simon Snapshot questionnaire in an effort to reduce the time necessary to complete the questionnaire survey respondents were limited in terms of the number of answers they were able to give to a particular question. The questionnaire also used very short time periods for some survey questions (e.g. the number of presentations to various health services in the previous month) thereby again reducing the amount of time required for questionnaire completion but also placing some limits of the nature of the data collected.

Timing

The survey was undertaken during July when attendance at some Simon services can be less than at other times of the year, for example demand for services can increase as the days shorten and the weather become more inclement, etc. It is unlikely therefore that the survey captures the entire spectrum of Simon Services users.

Survey Administration

Where Simon staff administering the questionnaire were known to the survey respondents this could have affected the respondents' willingness to disclose personal information for examples in relation to illegal drugs or indeed drug use patterns. Simon staff were asked to assess whether survey participants had any visible signs of "undiagnosed" mental and physical health status assessments of survey respondents. This assessment while providing very useful information can only be considered indicative.

Underreporting by Survey Respondents

FEANTSA, 2006 research has consistently found that people who are homeless tend to underestimate the extent of their health (especially mental health) problems. The reasons for this are thought to relate to the fact that "...*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.*

Gaps in the Questionnaire Content

The questions in relation to alcohol and drug use are limited by the fact that the questionnaire did not include questions in relation to the extent, frequency or quantity of drug and/ or alcohol use or indeed ask whether a person who may not currently be a problematic alcohol or drug user whether they had been in the past[5].

3 Findings

3.1 The profile of survey respondents

Approximately 75% of the survey respondents were men, 25% were women. This reflects the findings of the 2008 Homeless Agency's Survey[6] which found that the majority of people who are homeless are men. The average age of survey respondents was 43 years. The women who participated in this snapshot were aged from under 19 to over 80. 24% of the female survey participants were aged 50 or over, while 4.1% were aged 65 and over. See Figure 3.1 for details of the age ranges of the female respondents. The average age of the female respondents was 40 years. The male respondents were aged from under 19 years to over 85. Approximately 37% of the male respondents were age fifty or over with 6.7 % of these aged 65 or over[7]. See Figure 3.2 for details of the spread of age ranges of the male respondents. The average age of the male survey participant was 44.5 years. This figure and the figure for the average age of female respondents are broadly comparable with the findings of the 2008 'Counted In' survey which found the average age of homeless service users in Dublin was 39 (the average age of the 2010 Simon Snapshot participants was 42.5 years).

[5] 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).
[6] Homeless Agency (2008) Counted In Survey.
[7] 29% of participants in the 2010 Simon snapshot were aged over 55

Figure 3.1 Analysis of the ages of female respondents

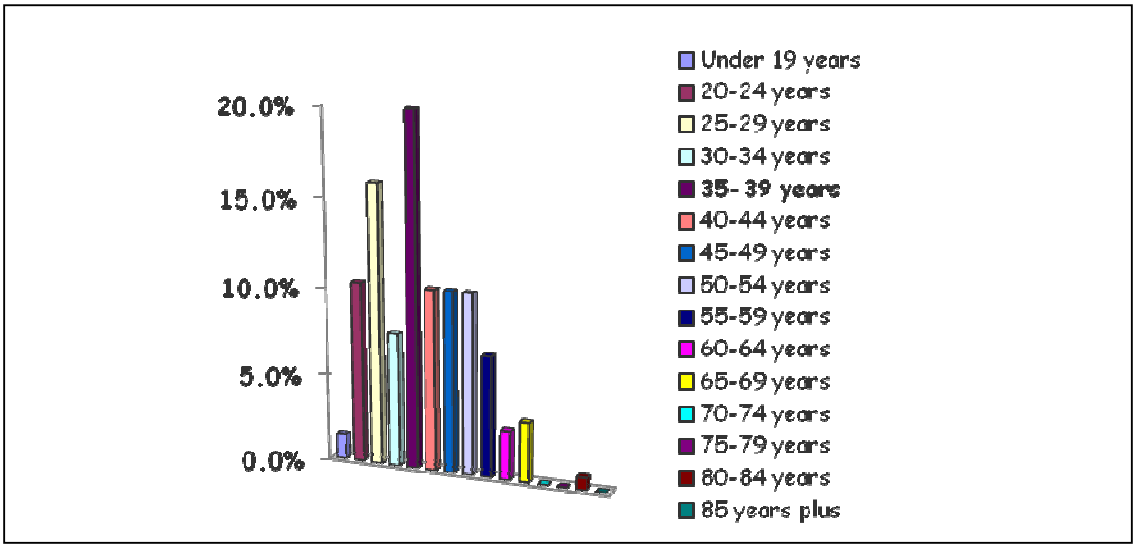
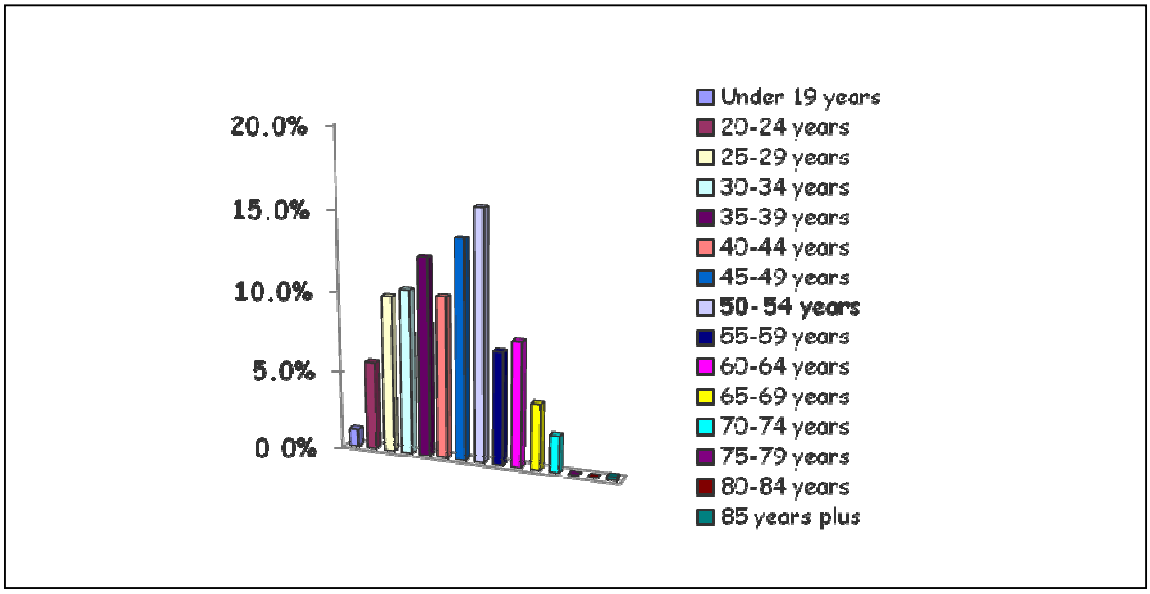


Figure 3.2 Analysis of the ages male respondents



The majority (86%) of survey respondents were Irish, UK citizens made up the next most numerous group (7%) while there were also Eastern Europeans (4%), Africans (1.4%) and well as a small number of respondents from a variety of other backgrounds. The majority of non Irish nationals were male, with only 25 female non Irish nationals, the majority (68% (17 respondents)) of which were UK citizens.

Income support

506 (85% question respondents) of the respondents surveyed were medical card holders, while 54 (9% question respondents) had a pension the majority of whom were men (48 respondents (88%) only 6 women indicated that they were in receipt of a pension. Interestingly almost 50% (280 question respondents) were in receipt of a disability allowance. 27 respondents (over 4% of the total sample) also reported that they were in receipt of other illness related benefits, These figures are high compared with the 2006 Census[8] which found that 9.3 per cent of population had a long lasting health problem or disability with incidences of disability higher in urban than in rural areas and among the older population. They provide a strong indication of the high level of complex health needs among survey respondents and people who access services from Simon in particular.

Eligibility for a variety of social welfare payments[9] is dependent on being able to prove that you meet the Habitual Residency Condition (HRC) criteria. 31 (5%) of the respondents surveyed indicated that they were affected by the Habitual Residency Condition (HRC) and therefore ineligible for a variety of social assistance payments. 11 of these respondents were Irish.

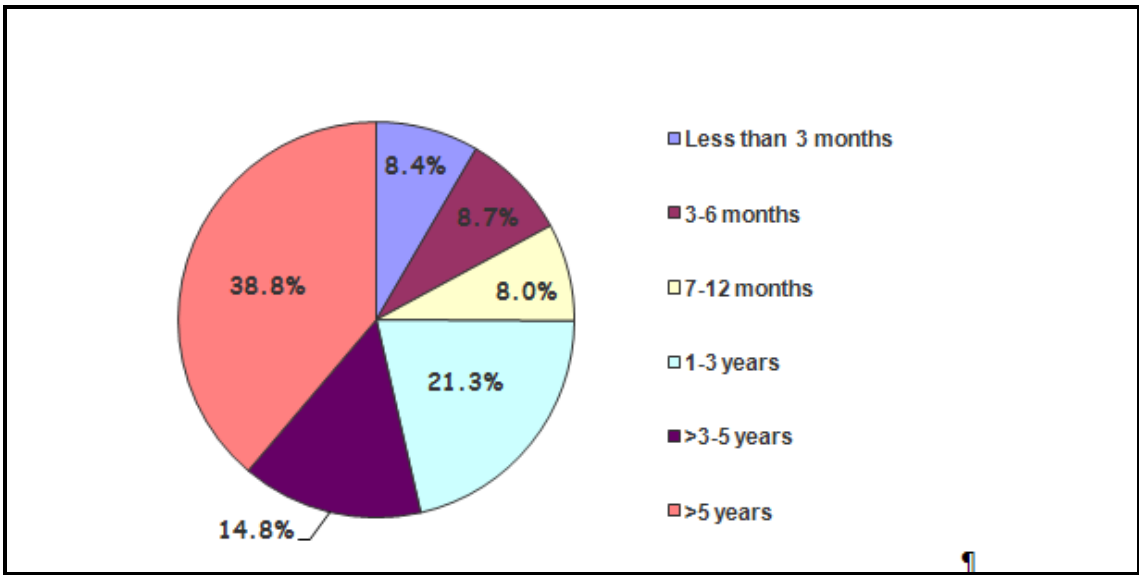
3.2 Experiences/s of homelessness

One of the most important pathways out of homelessness is through the assistance of a local authority. Respondents who become homeless ideally should register as homeless with their local authority as they may be able to assist the individual. Registration as homeless should also improve a person's longer term housing opportunities. The survey found 302 of the survey respondents registered as homeless. Early engagement with Simon supports and particularly tenancy and settlement supports means that some Simon clients do not consider that they have ever been homeless or indeed at risk of harmlessness. This provides some explanation for the somewhat smaller numbers (263 people) of survey respondents who indicated that they were currently homeless. 51 people (8.5%) declined to answer this question. Of the people that indicated they were currently homeless, 197 of these were homeless for more than a year (102 were homeless for greater than five years, 39 were homeless for 3-5 years and 56 were homeless for 1-3 years), while 66 people were homeless for a year or less. See Figure 3.3 for an analysis of the length of time people are homeless.

[8] Census 2006 Volume 11 – Disability, Carers and Voluntary Activities

[9] Blind Pension, Carer's Allowance, Child Benefit, Disability Allowance, Domiciliary Care Allowance, Guardian's Payment (Non-Contributory), Jobseeker's Allowance, One-Parent Family Payment, State Pension (Non-Contributory), Supplementary Welfare Allowance and Widow's, Widower's or Surviving Civil Partner's (Non-Contributory) Pension.

Figure 3.3 Analysis of the length of time survey respondents are homeless.



Accommodation Type
Survey respondents reported living in a variety of different accommodation types see Table 3.1 for a breakdown of the different accommodation types used by survey respondents.

Table 3.1. Analysis of current accommodation types

Options	*No of Responses*	*Percentage*
B&B	4	0.7%
Emergency Accommodation	140	23.8%
High[10] Support Housing	118	20.0%
Local Authority -with no support	26	4.4%
Local Authority - with visiting support	56	9.5%
Low[11] Support Housing	57	9.7%
Medium[12] Support Housing	39	6.6%
Owner Occupier	13	2.2%
Private Rented - with no support	16	2.7%
Private Rented - with visiting support	24	4.1%

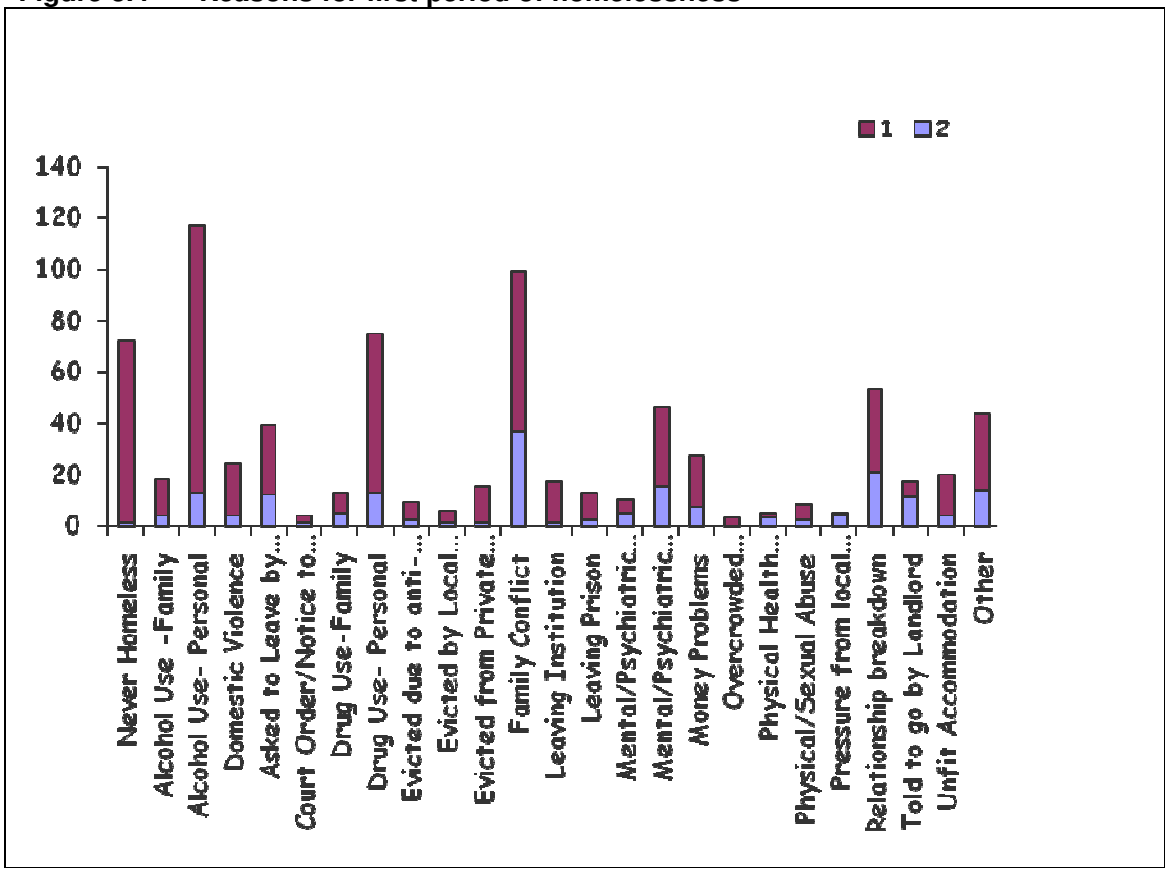
[10] High support housing is defined in No Room to Move (2004) by Homeless Link as housing where there is 24 hour staff cover available
[11] Low support housing is defined in No Room to Move (2004) by Homeless Link as housing where staff visit as required, offer advice and onward referrals.
[12] Medium support housing is defined in No Room to Move (2004) by Homeless Link as housing where there is a key-work system in place and staff are available onsite.

Residential Rehab/Detox facility	12	2.0%
Rough Sleeping	29	4.9%
Social Housing - with visiting support	43	7.3%
Squat	2	0.3%
Transitional Accommodation	10	1.7%
Non responses	14	

Reasons for becoming homeless

There are a number of different causes for homelessness; generally it's a combination of structural factors and personal factors/triggers. Survey respondents indentified a variety of reasons why they first became homeless. See Figure 3.4 for details of the reasons for the first period of homelessness. Respondents could indentify up to two reasons and most did, suggesting that there is generally more than one reason for becoming homeless.

Figure 3.4 Reasons for first period of homelessness



Other reasons identified as key contributory factors to a first period of homelessness included:

- Being asked to leave by family (37 respondents)
- Money problems (28 respondents)

- Domestic violence (22 respondents)
- Unfit accommodation (21 respondents)
- Family alcohol use (20 respondents)
- Being told to do by a landlord (17 respondents)
- Leaving an institution (16 respondents)
- Being evicted from private rented accommodation (14 respondents)
- Family drug use (12 respondents)
- Leaving prison (12 respondents)
- Family mental/psychiatric health issues (10 respondents)

Reasons identified by less than 10 respondents included being evicted due to anti-social behaviour (8 respondents) and victim of physical/sexual abuse (8 respondents). Reasons indentified by five or less respondents included pressure from the local community (5 respondents), eviction by a local authority (5 respondents), court order/notice to quit served (4 respondents), physical health problems (4 respondents) and overcrowded accommodation (3 respondents).

The five most frequently cited reasons for the first period of homelessness were:

1. Personal alcohol use was a cause of homelessness for 22% respondents.
2 Family conflict was a cause of homelessness for 19% respondents.
3 Personal drug use was a cause of homelessness for 14% respondents.
4 Relationship breakdown was a cause of homelessness for 10% respondents.
5 Personal mental/psychiatric Issues were a cause of homelessness for 9% of respondents.

There were some differences between male and female respondents in terms of the reasons they first become homeless. See Table 3.2 for the five most frequently cited reasons by gender.

Table 3.2. Reasons for first period of homelessness broken down by gender

The five most frequently cited reasons for first period of homelessness among men		*The five most frequently cited reasons for first period of homelessness among women*	
Reason	*Frequency of Responses*	*Reason*	*No of Responses*
Alcohol Use- Personal	96	Family Conflict	26
Family Conflict	73	Alcohol Use- Personal	20
Drug Use- Personal	60	Domestic Violence	18
Mental/Psychiatric Issues- Personal	42	Drug Use- Personal	15
Relationship breakdown	42	Relationship Breakdown	11

This analysis suggests that domestic violence is one of the key reasons for women becoming homeless, while psychiatric issues are more of an issue for men.

3.3 Health Status

This section is divided into four sub-sections:

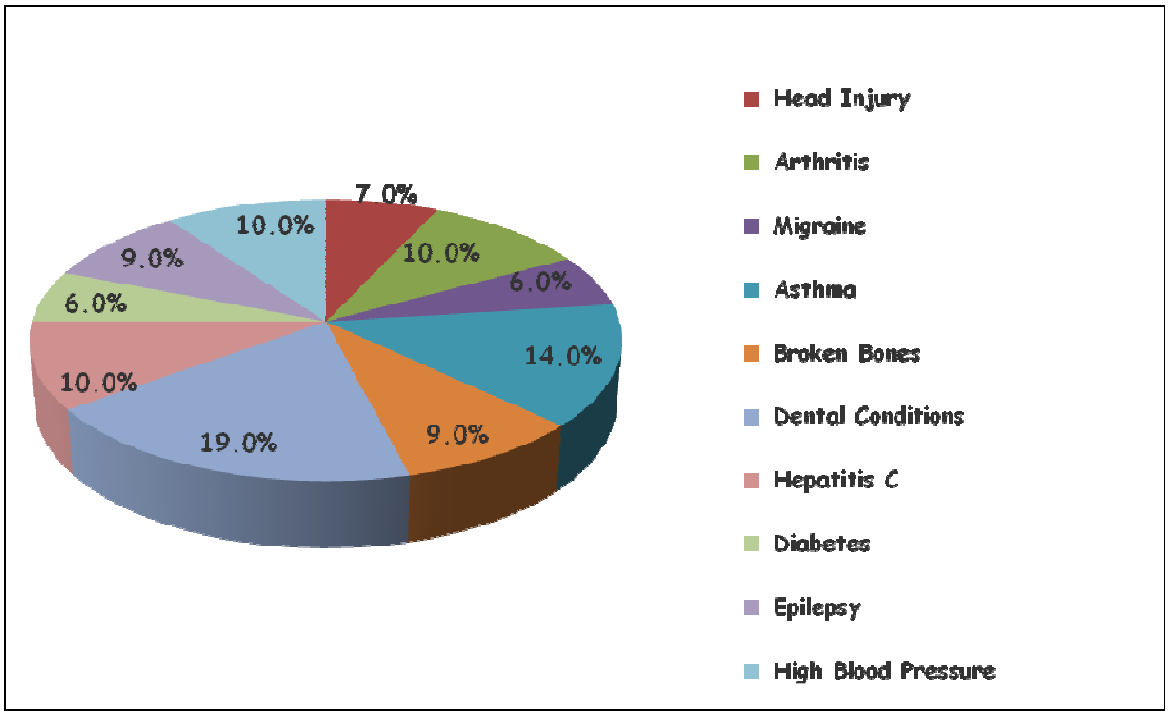
- Physical health
- Mental health
- Intellectual Disability
- Behavioural issues
- Diagnosed physical and mental health conditions.

Physical Health

Diagnosed Conditions

392 (65%) survey respondents provided details of the various physical medical conditions they had been diagnosed with, see Figure 3.5 for details of the 10 most frequently occurring physical health conditions. Among the most frequently occurring health issues was dental related issues, reinforcing the findings of earlier research by Condon in 2001)[13] who found that 98% of the people she examined who were homeless needed dental treatment. Table 3.3 provides a breakdown of all of the various physical health conditions more than five survey respondents had been diagnosed with.

Figure 3.5 The 10 most frequently occurring physical health conditions



[13] Condon, M. (ed.) (2001) The Health and Dental Needs of Homeless People in Dublin. Northern Area Health Board

Table 3.3. Physical Health Conditions more than five survey respondents had been diagnosed with	
Answer Options	*No of Responses*
Dental Conditions	93
Asthma	70
Hepatitis C	51
Arthritis	48
Broken bones	46
Migraine	32
Head Injury	31
Cuts & Bleeding	29
Cirrhosis (Liver Disease)	27
Kidney Infection	24
Cardiovascular Disease	22
Anaemia	20
Deafness & Hearing Problems	19
Angina	17
Incontinence	17
Bronchitis	16
Psoriasis	11
Gastroenteritis	13
Cancer	9
Haemorrhoids	9
Constipation	9
Slipped Disc	9
Osteoporosis	7
Gallstones	7
Acquired brain injury	6

Conditions reported by five or less respondents included: jaundice, pressure sores, conjunctivitis, hardened arteries, septicaemia, head lice, sexual health, hepatitis A, minor stroke, hepatitis B, motor neuron disease, developmental amnesia, spinal muscular atrophy, multiple sclerosis, tuberculosis, gangrene as well as a variety of other conditions.

Undiagnosed Conditions

Simon Community staff also identified visible signs of a number of as yet un-diagnosed physical health conditions among 173 (almost 29%) respondents. The most frequently occurring of the undiagnosed physical health conditions were fatigue (31 respondents), long term physical impairment (27 respondents), wounds and injuries (26 respondents), blood disorders (23 respondents), hepatic, skin disorders and respiratory disorders (21 respondents respectively), eye disorders (17 respondents), digestive disorders (15 respondents), muscle & bone disorders (14 respondents)as well as neurological disorders (10 respondents). Other conditions identified in lesser numbers among survey respondents included heart conditions (8 respondents), urinary problems (6 respondents), immune disorders, ear nose and throat problems (3 respondents) as well as a range of other conditions. The extent and nature of undiagnosed physical health conditions together with

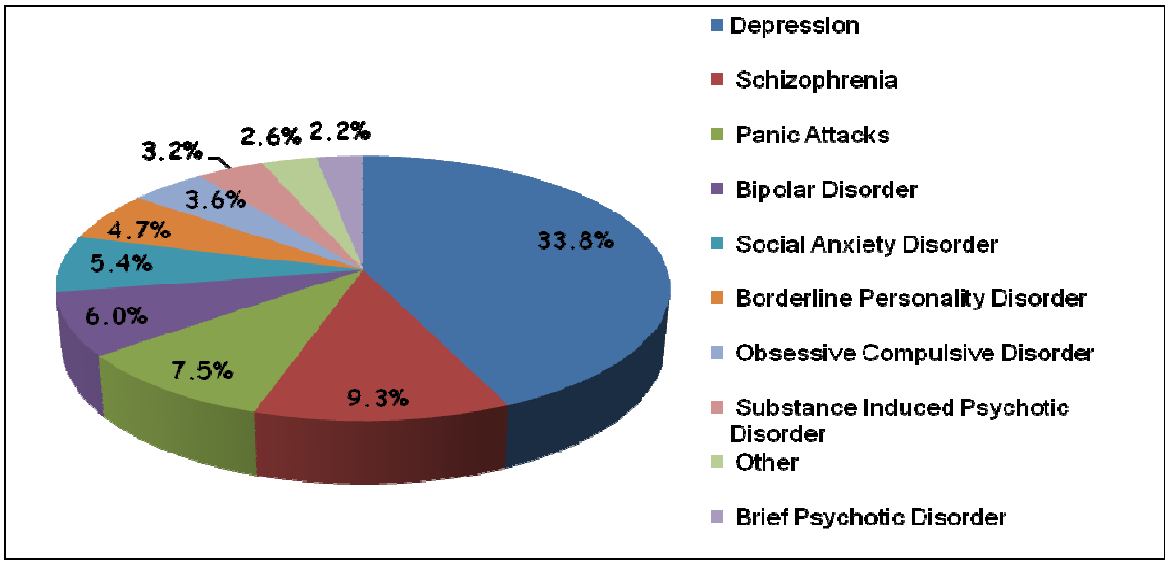
the diagnosed conditions gives an indication of the scale and the serious nature of the physical health conditions experienced by survey respondents.

Mental Health

Diagnosed Conditions

285 (47%) respondents reported having been diagnosed with at least one mental health condition. The most frequently reported mental health conditions, experienced by survey respondents was depression (181 respondents (30% survey respondents). See Figure 3.6 for details of the frequency of other conditions.

Figure 3.6 The 10 most frequently occurring mental health conditions



Other conditions experienced by survey respondents in smaller frequencies included: post traumatic stress disorder (11 respondents), delusional disorder (10 respondents), phobias (6 respondents), dementia (5 respondents), seasonal affective disorder (3 respondents), binge eating and anorexia nervosa (2 respondents respectively) and Alzheimer's disease (1 individual).

Undiagnosed Conditions

Simon staff also identified visible signs of a range of as yet undiagnosed mental health conditions among 154 respondents. The most frequently occurring undiagnosed mental health conditions were mood disorders (56 respondents) and anxiety disorders (49 respondents). Other undiagnosed conditions identified included sleep disorder (30) and mental decline (23 respondents) as well as developmental disorder (15 respondents), personality disorder (15 respondents), eating disorders and psychotic disorders (8 and 7 respondents respectively).

Physical Health, Mental Health and Housing

Appendix 1 provides a breakdown of diagnosed physical health conditions by accommodation type, while Appendix 2 provides a breakdown of diagnosed mental health conditions by accommodation type. See Table 3.4 for a summary of the finding of this analysis.

Table 3.4 Occurrence of Diagnosed Physical and Mental Health Conditions by Accommodation Type

Accommodation Type	Average No of Diagnosed Physical Health Conditions per respondent	Average No of Diagnosed Mental health Conditions per respondent
Owner Occupier	2.8	1.2
Local Authority -with no support	2.15	0.3
High Support Housing	2	0.9
Residential Rehab/Detox	2	0.6
Private Rented - with no support	1.8	0.8
Local Authority - with visiting support	1.7	0.7
Social Housing - with visiting support	1.6	0.9
Low Support Housing	1.5	1
Emergency Accommodation	1.3	0.7
Rough Sleeping	1.3	0.3
Private Rented - with visiting support	1	0.8
Medium Support Housing	0.9	0.7
Transitional Accommodation	0.6	0.8
B&B	1.8	0.3
Squat[14]	0	0

This analysis shows that the average survey participants had at least 1.4 diagnosed physical health conditions, while participants in some accommodation types (shaded) had significantly more than one condition. The incidence of diagnosed mental health conditions was less frequent (average 0.66 per respondent) but again some accommodation types showed significantly higher level of diagnosed mental health conditions that others. Survey respondents who were owner occupiers showed a particularly high incidence of physical and mental health conditions.

Physical Health, Mental Health and Length of Time Homeless

An analysis of the length of time survey respondents are homeless by diagnosed physical and mental health conditions respectively show that there are significant numbers of respondents with serious diagnosed health conditions who are homeless for over five years.

[14] Only two respondents indicated that they lived in this type of accommodation. Thus the findings of this analysis of health conditions cannot be seen as either reliable or capable of generalisation in this context.

Table 3.5. Length of Time Homeless by Diagnosed Physical & Mental Health Conditions							
Type of Conditions	*Length of Time Homeless*						
	< 3 months	*3-6 months*	*7-12 months*	*1-3 years*	*>3-5 years*	*>5 years*	*No. Of Responses*
Diagnosed Physical Health Condition	11	24	33	72	63	203	429[15]
Diagnosed Mental Health Condition	13	14	15	44	24	75	185[16]

Intellectual Disability

74 (over 12%) survey respondents reported having an intellectual disability. 74% (55 respondents) of these reported having a mild cognitive impairment, 15% (11 respondents) reported having been diagnosed with attention deficit disorder, while 12% (9 individual) had been diagnosed with autism. Analysis of the Irish National Intellectual Disability Database in Ireland by the Health Research Board suggests that the prevalence rate of intellectual disability is 7.38 per 1,000 of the total population. These statistics suggest that there is a higher level of intellectual disability within the survey respondents than would be expected within the wider population.

Intellectual Disability and Housing

The highest levels of survey respondents were found to be living in high support housing and in emergency accommodation. See Table 3.6 for a breakdown of the incidence of different intellectual disabilities[17] across different accommodation types.

[15] There is an element of double counting here as just 392 survey respondents indicated that they had been diagnosed with physical health conditions
[16] 285 respondents reported having been diagnosed with at least one mental health condition.
[17] Not all respondents provided details of accommodation type.

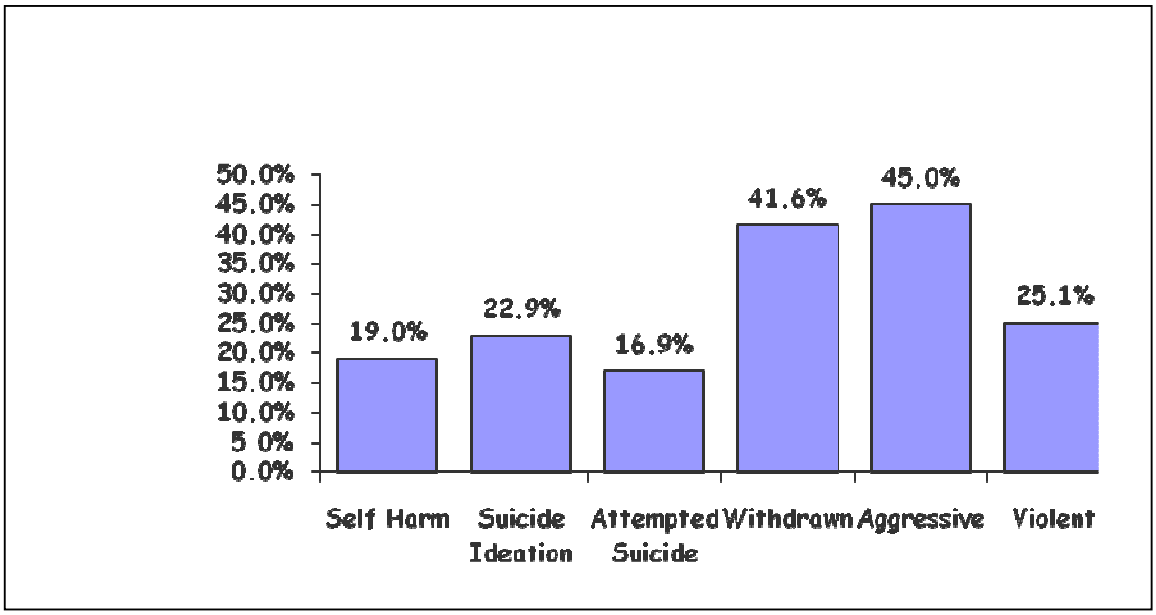
Table3.6 Intellectual Disability broken down by Accommodation Type				
Accommodation Type	*Intellectual Disabilities*			*Totals*
	Attention Deficit Disorder & Attention Deficit Hyperactivity Disorder	*Autism*	*Mild Cognitive Impairment*	
High Support Housing	4	5	18	27
Emergency Accommodation	4	1	8	13
Local Authority - with visiting support	0	0	6	6
Local Authority -with no support	1	0	3	4
Low Support Housing	0	1	3	4
Social Housing - with visiting support	0	0	4	4
Medium Support Housing	0	1	2	3
Private Rented - with visiting support	1	1	1	3
Owner Occupier	0	0	2	2
Private Rented - with no support	0	0	2	2
Rough Sleeping	0	0	2	2
Transitional Accommodation	1	0	1	2

Challenging Behaviour/s

Challenging behaviour is behaviour which: causes harm to the person, causes harm to others, causes stress to others, impedes learning, is contrary to social norms. Challenging behaviour is a generally a function of the interaction between the person and their current environment[18]. It is caused by a complex mix of factors including poor mental health, problem drug and alcohol use, etc. The survey found that 190 (32%) respondents reported presenting with challenging behaviour. The most frequently occurring types of challenging behaviours found among survey respondents were aggression (104 respondents) and withdrawal (96 respondents). Both of these behaviours pose particular challenges to healthcare staff and services seeking to support these respondents. The survey also found significantly higher levels of attempted suicide and/or suicide ideation and self harm behaviours among respondents when compared with national statistics[19]. See Figure 3.7 for details.

[18] Mahood, M (2007) Challenging behaviour in homelessness services. Turing Point Scotland.
[19] National Strategy for Action on Suicide Prevention 2005-2014 estimated that suicide mortality rates were approximately 12.9 per 100,000 of our population, with higher rates of youth suicide and indeed suicide among those in their 20s and early 30s, with men under 35 years accounting for approximately 40% of all Irish suicides. National deliberate self harm rates are 241 per 100,000 population for women and 177 per 100,000 for men.

Figure 3.7 Frequency of challenging behaviours among survey respondents



This section taken in its entirety presents a picture of a group of respondents with a range of complex and indeed interrelated mix of physical, mental, intellectual and behavioural challenges and issues.

Diagnosed physical and mental health conditions
275 persons (46% respondents) indicated that they had both diagnosed physical and diagnosed mental health conditions some individuals had a number of conditions.

3.4 Access to Healthcare

This section is divided into a number of sections:

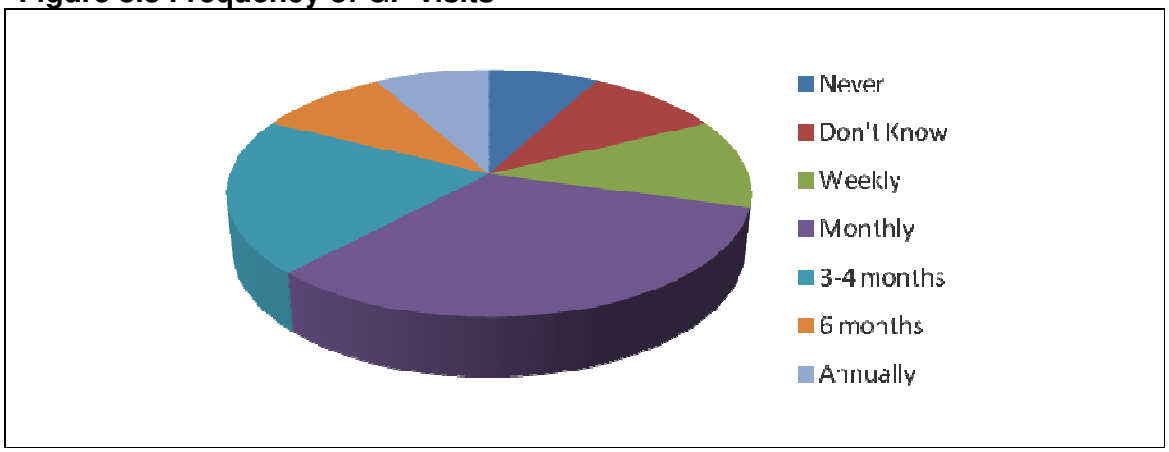
- Access to Primary Healthcare
- Access to Hospital Services
- Access to Mental Health Services
- Barriers to Health Care

Access to Primary Healthcare
The vast majority (558 (93%)) of survey respondents were registered with a GP, while 204 (34%) respondents used the services of a multidisciplinary team, a smaller number 144 (24%) used the services of Safety Net[20]. The majority (329 (55%)) of survey respondents used accident and emergency services. Other health care services accessed by survey respondents included counselling, drug treatment, physiotherapy and occupational therapy, dietician, home care, psychiatric services/clinics/mental health teams, dentistry, local health clinic, meals on wheels as well as methadone clinics. These findings suggest that survey

[20] Safetynet is a primary care network that provides a range of services to homeless people (including wound management, dental services, vaccinations, general nursing assessment, methadone maintenance, etc). It was established in 2007 and is funded by the HSE it currently operates in Dublin and Cork only, although there are proposals to develop the service in Dundalk.

respondents first point of call when unwell is either accident and emergency services, or their GP. This is despite the fact that 93% of respondents are registered with a GP. This view is supported by the fact that 101 respondents had either never visited their GP or could not remember their last visit to their GP, while 43% (259 respondents) visited their GP either weekly (69 respondents) or monthly (190 respondents). A further 218 visited their GP at least once a year with varying frequencies (119 respondents visited very 3-4 months), 55 visited every 6 months while 47 visited their GP annually. See Figure 3.8 for details.

Figure 3.8 Frequency of GP visits

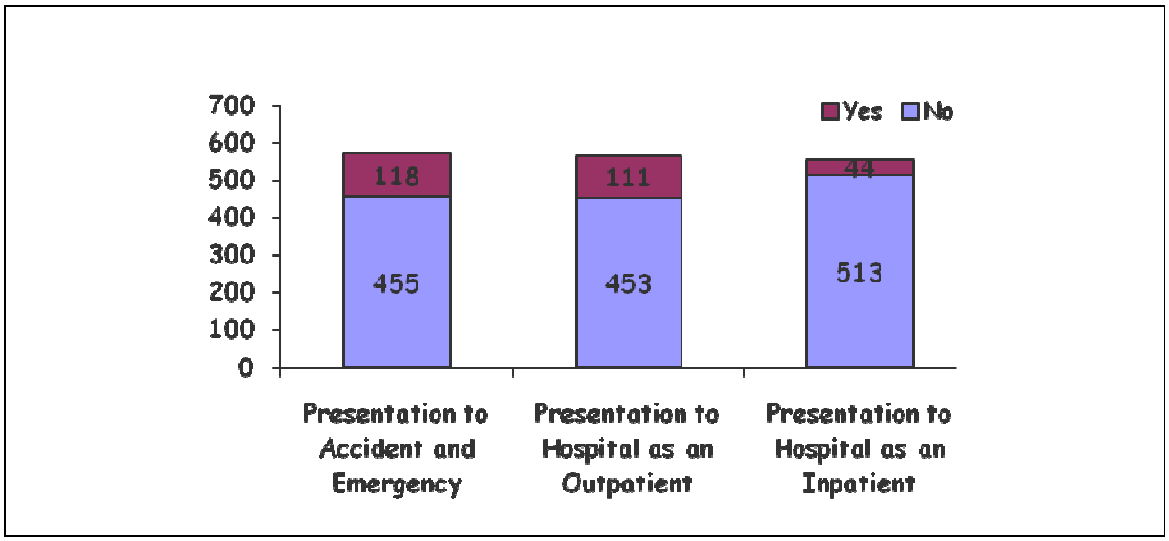


The frequency of respondents using Safety Net/Multi D team also varied, some used it weekly (49 respondents), others monthly (44), with 55 respondents using it less frequently than once a year. Frequency of visits to Multi D team paralleled the frequency of visits to Safety Net, with 56 respondents using the services weekly, 57 monthly and the remaining 55 again less frequently than once a year.

Access to Hospital Services

See Figure 3.9 for details of numbers accessing different hospital services (note that not all survey respondents answered these questions).

Figure 3.9 Numbers accessing different hospital services

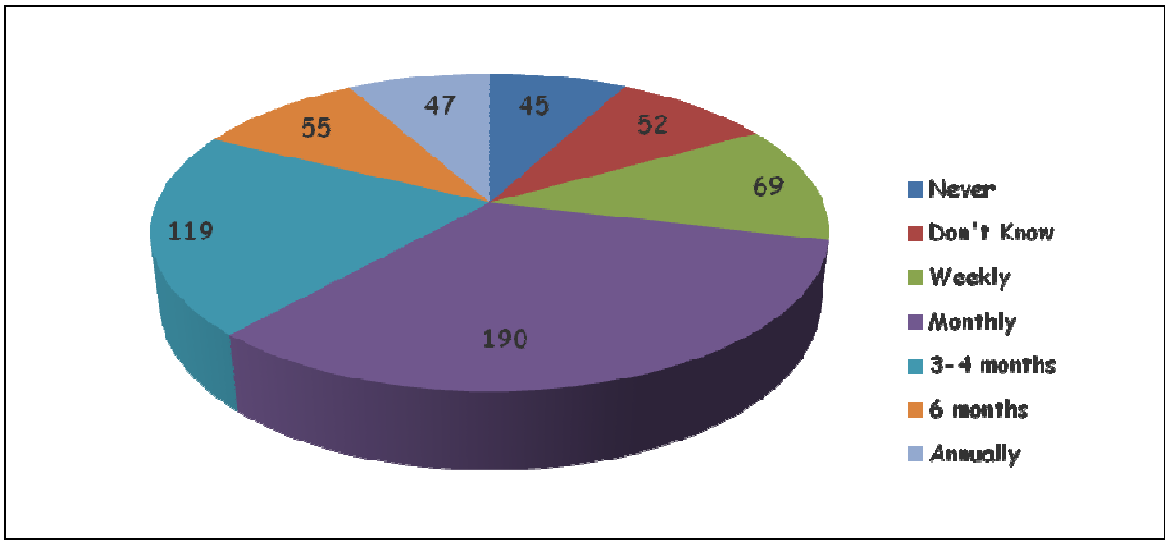


118 respondents indicated that they had presented to Accident and Emergency services in the previous month. The majority (83 individuals) had presented just once while the remainder had presented more than once (26 respondents had presented twice, 10 respondents had presented three times, while one individual had presented four times and two respondents had presented more than five times in the last month) suggesting the presence of chronic health issues for at least 39 respondents and/or that other services may not meeting the needs of these respondents.

97 (16%) survey respondents indicated that they had presented as a hospital outpatient in the last month, The majority (60 people) had presented only once, 23 people had presented twice while the remainder had presented on three, (six respondents), four (five respondents) and five or more occasions (three respondents).

79 (13%) of survey respondents had been a hospital inpatient in the previous month, again the majority (49 respondents) had presented once while the remainder had presented more frequently, (11 respondents had presented twice, three individuals had presented three times, two respondents had presented four times and again three individuals had been in hospital on more than five occasions. See Figure 3.10 for details.

Figure 3.10 Frequency of hospital in-patient admissions in the previous month



Access to Mental Health Services

86 (14%) of the respondents surveyed reported having presented to mental health services on an out-patient basis while 15 respondents reported having been admitted to mental health services as an in-patient in the months preceding the survey. The majority (15) of inpatient admissions happened once in the preceding month. The number of presentations to outpatient services was considerably higher at 93. 37 respondents presented on more than one occasion to out-patient services while eight respondents presented on five or more occasions. The relatively high number of survey respondents with mental health issues while stark is not surprising given that research studies have s consistently found higher rates of mental ill-health among the homeless population than among the population in general. Researchers[21] indeed estimate that between 25% and 50% of people who are homeless in Ireland experience mental health problems at some point in their life

The high numbers of the survey respondents accessing both physical and mental health services provide evidence of higher levels of ill health than would be found in the general population.

Barriers to Health Care

Over 21% of question respondents reported experiencing barriers to health care. The issue identified as the number one barrier by the most number of survey respondents was the absence of a medical card (37 respondents (38% of those that did not have a medical card), closely followed by previous negative experience which was identified by 35 respondents[22].

An analysis of the respondents who did not have a medical card found 23 respondents (19 men and 4 women) who did not have a medical card and who never visited their GP (17 of these respondents were in Dublin, 4 in Cork, 1 in Galway and 1 in Dundalk, 12 of these

[21] Amnesty International (2003) Mental Illness-The Neglected Quarter-Homelessness. Amnesty International All Ireland Section. McKeown, K (1999) Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions. Disability Federation of Ireland. Homeless Agency (2004) Making it Home: An Action Plan on Homelessness in Dublin 2004-2006. Homeless

22 85% of survey respondents were medical card holders.

respondents were Irish while 13 respondents indicated that they were affected by the Habitual Residence Conditions. Most worrying from a health perspective was the fact that 18 of these respondents indicated that they were currently homeless. In addition, of the respondents who did not have a medical card 22 of these were found not to be registered with a GP (only six had visited a GP in the previous year and only four had accessed the services of a multidisciplinary team). These figures suggest that the absence of a medical card can lead individuals who are homeless to become very isolated from the range of primary health care services available.

Survey respondents were asked to rank the barriers in terms of their significance, when this weighting was applied the absence of a medical card still remained the most significant barrier.

The prioritisation of other needs above health needs was also identified by 26 respondents as a significant barrier, while 25 survey respondents said the opening hours for services presented a barrier to them accessing services. The issue of cost was also indentified as a barrier by 24 respondents. The Habitual Residency Condition was also identified by 18 respondents as a barrier.

3.5 Problem Alcohol and Drug Use

This section is divided into two parts - alcohol use and drug use.

Alcohol Use

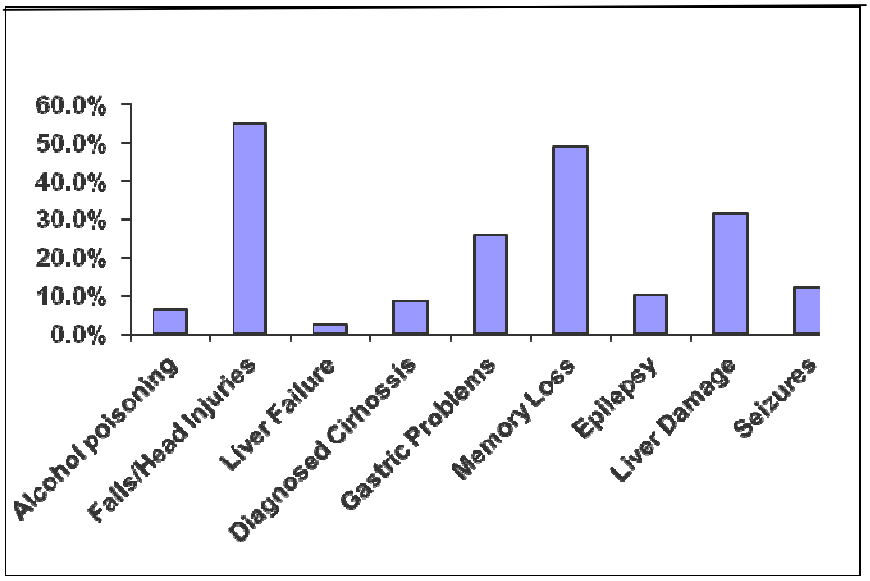
Over 50% (314) of survey respondents indicated that they were current alcohol users. The extent and nature of these respondents use of alcohol is unknown. See Table 3.7 for a breakdown of the numbers of respondents using alcohol by accommodation type.

Table 3.7 Number of respondents using alcohol by accommodation type.

Accommodation Type	*No of Respondents using Alcohol*	*% Respondents in this type of accommodation*	*Total no of Respondents living in this type of Accommodation*
Emergency Accommodation	88	64	137
High Support Housing	81	70	116
Local Authority -with no support	9	36	25
Local Authority - with visiting support	31	57	54
Low Support Housing	22	40	54
Medium Support Housing	21	55	38
Owner Occupier	8	61	13
Private Rented - with no support	5	33	15
Private Rented - with visiting support	6	30	20
Rough Sleeping	17	63	27
Social Housing - with visiting support	15	38	40
Squat	1	50	2
Transitional Accommodation	6	60	10
B&B	0	0	2
Residential Rehab/Detox	0	0	12

Alcohol generated heath issues for 171 respondents (28% total sample) and that 55 (9%) of the respondents surveyed had attended a detox facility in previous 12 months. See Figure 3.10 for details of the extent of heath complications arising from alcohol use. 139 respondents (44% current alcohol users) who indicated that they were current alcohol users also had alcohol related health issues. See Figure 3.11 for details.

Figure 3.11 Alcohol related health conditions experienced by current alcohol users



A comparison between the five most frequently occurring alcohol related conditions and the diagnosed physical health conditions (occurring in more than five respondents) provide a good indication of the complexity of the health issues survey respondents live with. See Table 3.8 for details.

Table 3.8. Frequently Occurring Alcohol Related Conditions and Diagnosed Physical Health Conditions						
Answer Options	*Alcohol poisoning*	*Falls/Head Injuries*	*Gastric Problems*	*Memory Loss*	*Liver Damage*	*Response*
Dental Conditions	3	14	13	22	13	31
Cirrhosis (Liver Disease)	3	12	12	15	19	25
Asthma	0	14	8	7	11	25
Broken bones	3	18	7	14	5	21
High Blood Pressure	2	9	4	14	9	21
Hepatitis C	3	12	6	10	11	20
Head Injury	5	16	6	15	8	19
Arthritis	2	9	7	7	7	19
Cuts & Bleeding	2	12	4	12	5	19
Epilepsy	1	9	2	8	5	15
Cardiovascular Disease	2	7	4	7	7	13
Incontinence	1	8	6	9	6	12
Kidney Infection	1	5	2	4	4	11
Angina	2	6	3	6	6	10
Bronchitis	1	7	5	7	3	10
Chiropody Conditions	1	7	6	5	3	10
Psoriasis	1	5	3	4	1	7
Migraine	2	2	0	6	3	7
Gastroenteritis	2	4	4	3	4	7
Deafness & Hearing Problems	0	3	0	4	1	6
Anaemia	1	2	4	2	3	6
Diabetes	1	5	3	1	4	6
Acquired brain injury	1	4	1	4	2	5
Pulmonary Disease (COPD)	1	4	3	3	3	5
Pneumonia	1	3	2	3	3	5

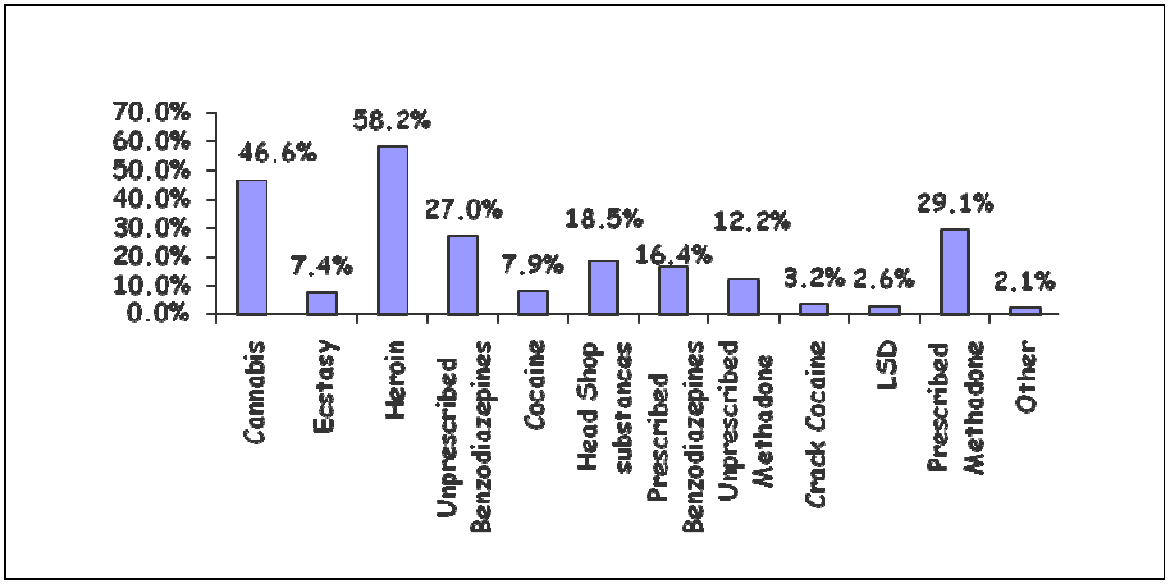
Drug Use

189 respondents (over 31% total survey sample) identified themselves as current drug users. The highest level of drug use was found among rough sleepers and respondents using emergency accommodation. See Table 3.9 for a breakdown of drug use across the different accommodation types.

Table 3.9 Drug Use broken down by Accommodation Type			
Accommodation Type	*No of respondents using drugs*	*% of this type of Accommodation users*	*Total no of Respondents living in this type of Accommodation*
Emergency Accommodation	75	55	136
High Support Housing	39	34	116
Local Authority - with visiting support	4	9	53
Low Support Housing	1	2	50
Social Housing - with visiting support	5	12	42
Medium Support Housing	5	14	35
Rough Sleeping	18	64	28
Local Authority -with no support	5	21	24
Private Rented - with visiting support	4	25	20
Private Rented - with no support	8	50	16
Owner Occupier	2	15	13
Residential Rehab/Detox	0	0	12
Transitional Accommodation	5	50	10
B&B	1	25	4
Squat	2	100	2

26 respondents had attended a drug detox facility in the previous 12 months, while 77 respondents (43% of current drug users) had viral screening in the previous 12 months. See Figure 3.10 for details of the drugs used by current drug users.

Figure 3.10 Extent and nature of drug use among current drug users

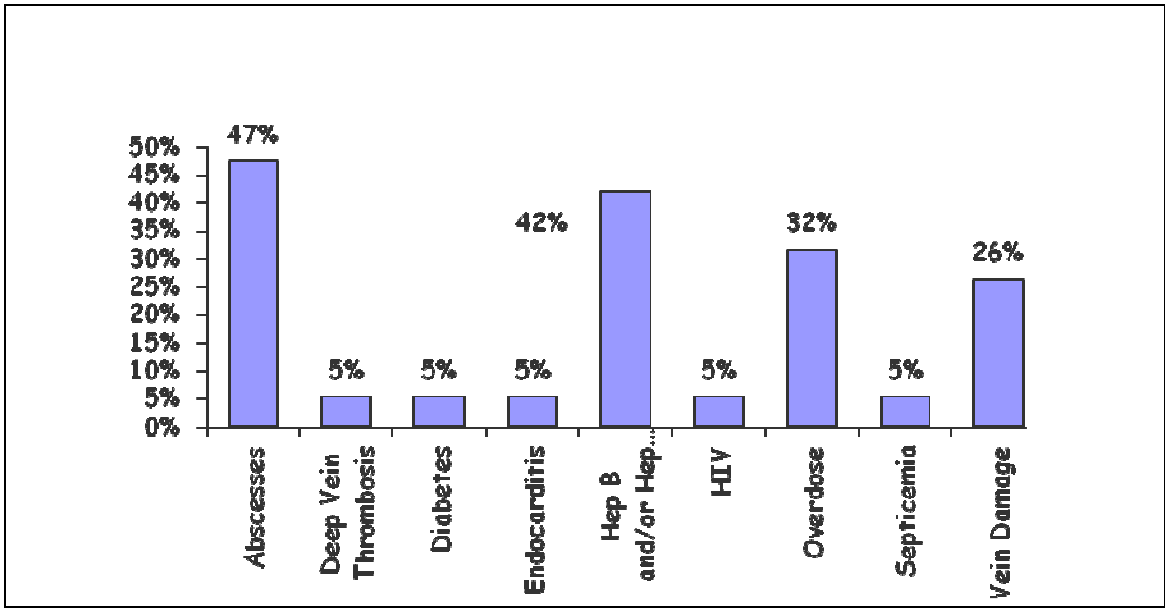


Heroin was the most frequently used drug among the respondents (>58%) that indicated they were current drug users, the second most frequently used drug was cannabis (used by almost 47%). The next more frequently used drug was methadone (41.3%) (made up of 29.1% prescribed methadone and 12.2%) unprescribed methadone). The frequency of use of prescribed methadone is lower than might have been expected given that 46% of this drug using group indicated in a separate question that they had been prescribed methadone in the last 12 months. Un-prescribed benzodiazepines use was also high at 27%.

143 (76% drug users) respondents used more than one drug. 53 (28% drug users) used two drugs, 85 (45% drug users) used three drugs, 5 respondents used four drugs and two respondents used more than five drugs. These figures highlight the extent of polydrug use among the sample population.

More than half 52% (93 respondents) of those currently using drugs had used IV drugs in the previous 12 months while almost 50% (83 respondents) of this group reported experiencing health complications through IV drug use. See Figure 3.11 for any analysis of the extent of complications experienced.

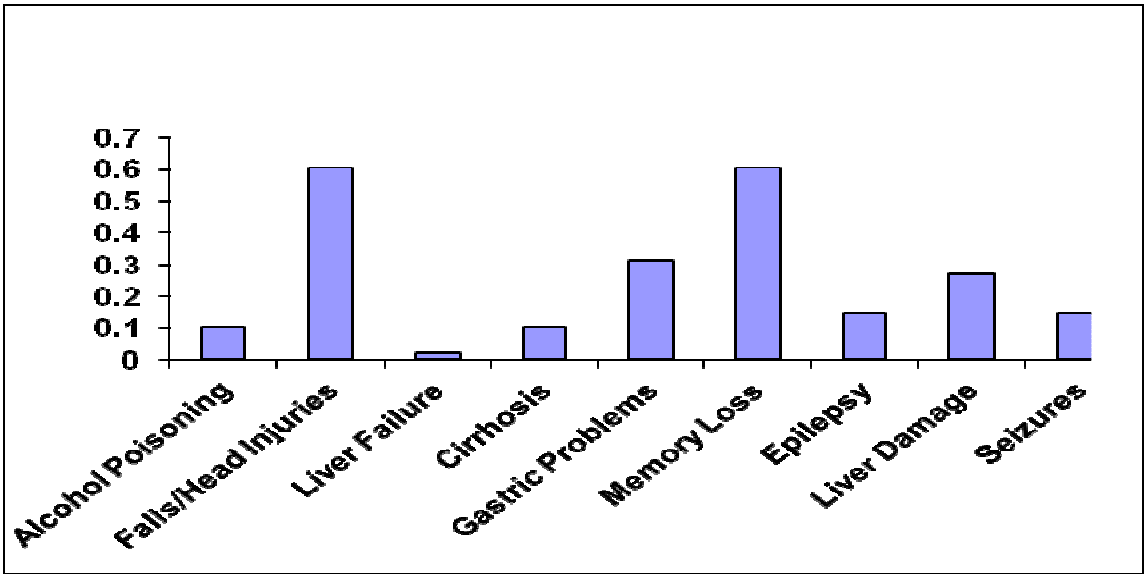
Figure 3.11 Complications arising from IV drug use drug among respondents



Problem Alcohol and Drug Use

32 respondents (9 females and 23 males) had a variety of complex health problems associated with alcohol and health problems associated with drug use. These respondents (who tend to be located in the more urban centres (Dublin 19, Cork 10 and Galway 3)) clearly pose particular challenges for health services, seeking to meet the very complex and interrelated physical and mental health needs of this group. See Figure 3.12 for details of the frequency of the occurrence of different alcohol related health conditions among respondents with health complications from IV drug use.

Figure 3.12 Frequency of alcohol related health conditions among respondents with IV drug use related health complications



3.5 Dual Diagnosis and Complex Needs

The 2005 NACD study found that people who are homeless are more likely than the general population to experience a dual diagnosis of mental health and problematic drug and/or alcohol use problems due to environmental factors, particularly the lack of supported housing.

The exact prevalence of dual diagnosis among survey respondents is not known given that survey respondents generally had a range of complex combinations of different health conditions. Table 3.10 provides an indication of the mix of diagnosed mental health and alcohol related conditions

Table 3.10 Diagnosed Mental Health Conditions and Alcohol Related Heath Conditions								
Most Frequently Occurring Diagnosed Mental Health Conditions	*Most Frequently Occurring Alcohol Related Heath Conditions*							
	Memory Loss	*Falls/Head Injuries*	*Liver Damage*	*Gastric Problems*	*Seizures*	*Epilepsy*	*Diagnosed Cirrhosis*	*Alcohol poisoning*
Binge Eating	1	1	0	1	1	0	0	0
Panic Attacks	11	6	8	4	3	1	2	1
Social Anxiety Disorder	6	3	2	3	1	2	2	3
Alzheimer's Disease	1	1	1	1	0	0	1	1
Dementia	3	2	1	1	0	0	1	1
Delusional Disorder	4	3	1	2	1	0	0	0
Substance Induced Psychotic Disorder	3	0	2	1	3	2	1	1
Anorexia Nervosa	7	4	2	4	0	0	1	1
Bipolar Disorder	1	1	1	0	1	2	1	1
Depression	7	4	3	3	15	10	8	1
Post Traumatic Stress Disorder	39	36	28	24	2	0	1	7
Brief Psychotic Disorder	4	2	4	1	0	1	0	1
Borderline Personality Disorder	1	3	0	1	1	3	1	0
Obsessive Compulsive Disorder	6	2	3	5	0	1	0	1
Schizophrenia	1	1	1	1	3	0	2	0

Table 3.11 provides an indication of the mix of mental health conditions and health complications from IV drug use.

Table 3.11 Diagnosed Mental Health Conditions and Health Complications from IV Drug Use

Answer Options	*Abscesses*	*DVT*	*Diabetes*	*Endocarditis*	*Hep B and/or Hep C*	*HIV*	*Overdose*	*Septicaemia*	*Vein Damage*
Panic Attacks	2	1	0	0	2	0	1	0	1
Social Anxiety Disorder	2	0	0	1	1	0	1	0	1
Delusional Disorder	0	0	0	1	0	1	1	0	1
Phobias	1	0	0	1	1	0	1	0	1
Substance Induced Psychotic Disorder	1	0	0	0	2	0	0	0	2
Bipolar Disorder	1	0	0	0	1	0	1	0	0
Depression	13	4	3	1	11	1	7	1	7
Brief Psychotic Disorder	1	1	0	0	0	0	0	0	1
Borderline Personality Disorder	2	1	0	0	1	0	0	0	3
Obsessive Compulsive Disorder	2	0	0	0	4	1	1	0	3
Schizophrenia	2	1	0	0	3	0	2	0	1

An overall analysis of the survey findings has lead to the identification of 20 respondents with diagnosed mental health conditions as well as alcohol and drug related conditions. The most frequently occurring mental health conditions in this context were Depression (14 individuals) Borderline Personality Disorder (5 respondents), Delusional Disorders, Substance Induced Psychotic Disorder and Brief Psychotic Disorder (2 respondents for each condition respectively). Some respondents had more than one diagnosed mental health condition and indeed more than one alcohol and/or drug related condition. It was also possible to identify 11 respondents with undiagnosed mental health conditions and alcohol and drug related heath conditions while 18 individuals were found to have undiagnosed physical health conditions and alcohol and drug related heath conditions. These respondents also had a range of diagnosed physical health conditions. See Table 3.12 for details of the most frequency occurring physical health conditions among this group.

Table 3.12 Most Frequently Diagnosed Physical Health Conditions among survey respondents with a dual diagnosis	
Most Frequently Occurring Physical Health Conditions[23]	*No of Respondents*
Hepatitis C	10
Cirrhosis (Liver Disease)	8
Asthma	8
Cuts & Bleeding	6
Broken Bones	7
Dental Conditions	6
High Blood Pressure	6
Epilepsy	5

A larger group of 48 (39 men and 9 women) respondents were also identified as part of the analysis as being at risk of dual diagnosis i.e. drug users with alcohol related health conditions and a range of diagnosed physical and mental health conditions. The majority (32) of these respondents were in Cork with smaller numbers in Dublin (14 respondents) and Galway (2 respondents). 75% of this group were Irish.

4 Conclusions

4.1 Health Needs of People who are Homeless

The profile of the survey participants (age, gender, nationality, etc) can be seen to be broadly representation of the wider homeless population. Survey respondent's experiences of homelessness were also found to be broadly representative of the wider homeless population with almost a third of the survey sample homeless for more than a year and 102 respondents homeless for more than five years. It was not surprising therefore to find that a significant number of the survey population living in emergency accommodation. There are a number of different causes for homelessness, generally it's a combination of structural factors and personal factors/triggers. The most frequently cited pathways into homelessness cited in this study were personal alcohol and or drug use, family conflict and relationship breakdown and personal mental/psychiatric health issues and in the case of women domestic violence. The snapshot found that a significant number of people who were homeless for over five years had serious diagnosed physical and mental health conditions.

4.2 Access to health services

The survey found that while the majority of survey respondents were registered with a GP at least 18% of this group (many of whom did not have a medical card) did not visit their GP. Survey respondents were found to access their primary healthcare supports from a variety of sources including their GP, Multidisciplinary Teams and Safety Net services where they existed. The most frequently accessed primary care service was the GP, the next most frequently accessed service was Accident and Emergency. Other key health care services accessed by survey respondents included counselling, drug treatment, physiotherapy and occupational therapy, dietician, home care, psychiatric services/clinics/mental health teams, dentistry, local health clinic, meals on wheels as well as methadone clinics.

[23] Respondents often had more than one physical health condition.

Survey respondents accessed Accident and Emergency services and hospital outpatient services in almost equal amounts with smaller numbers admitted as inpatients. Most hospital presentations were one-off, however the survey also found a small group of respondents who had presented on a number of occasions, suggesting the existence of significant levels of ill health among this smaller sub-group. While the numbers presenting to mental health services was smaller than the numbers presenting to general hospital services, there was again a small group of respondents presenting on a number of occasions. The high percentage of survey respondents accessing both physical and mental health services provide evidence of higher levels of ill health than would be found in the general population.

4.3 Barriers to Health Care

The key barrier which had been experienced in relation to accessing health care was found to be the absence of a medical card, closely followed by previous negative experience of accessing health services. Both of these issues need to be recognised and addressed by the wider health service. It is reassuring to note the 85% of the sample were now medical card holders.

4.4 Health status

The survey found that 65% of all of the respondents surveyed had been diagnosed with at least one physical health condition, and 47% (285) of respondents had been diagnosed with at least one mental health condition. These figures coupled with the estimation by Simon staff that there were also 173 (almost 29%) of respondents with undiagnosed physical health conditions and 153 respondents with undiagnosed mental health conditions provides a picture of a group of people grappling with a complex mix of chronic health conditions.

Many of the most frequently occurring health conditions/issues can be seen to be connected to poor living conditions associated with homelessness (arthritis, asthma, depression etc), and/or problem drug and alcohol use and/or neglect of ongoing health issues (such as dentistry related concerns). The survey also found that there was a higher than average level of intellectual disability within this group as well as the existence of significant levels of behavioural issues causing problems for the individual and indeed for the services and personnel seeking to support these respondents.

4.5 Problem drug and alcohol use

50% reported being current alcohol users while 30% reported being current drug users. The survey found that alcohol generated a range of health issues for 28% of the survey sample while 83 individual drug users reported experiencing a variety of health complications through IV drug use. The survey also found a small group (9 females and 23 males) who had a variety of complex health problems associated with alcohol and drug use. These respondents (clearly pose particular challenges for health services, seeking to meet the complex physical and mental health needs of this group.

4.6 Dual Diagnosis and Complex Needs

The survey found complex combinations of mental health and alcohol related conditions among survey respondents. It also found respondents with mental health and IV drug use

related health conditions. It was also possible as part of the analysis to identify a small group who had mental health and alcohol and IV drug related health complications. Approximately 8% of respondents were identified as part of the analysis as being at risk of dual diagnosis i.e. drug users with alcohol related health conditions and a range of diagnosed physical and mental health conditions.

4.7 In Conclusion

The survey found respondents with high levels of physical and mental illness and problematic drug and/or alcohol use. Respondents frequently had complex and overlapping health conditions and problematic drug and alcohol use. The treatment of these complex health conditions clearly requires a range of interventions. The survey has found that many respondents present infrequently or in some cases not at all. Cost was clearly identified as a key barrier for respondents seeking to access health services. Having a medical card is key to accessing services. The absence of a medical card, the chaotic nature of many respondents' lives (dependent as they are on emergency or temporary/informal accommodation options) together with previous negative experience of health services and the prioritisation of other more immediate needs (e.g. shelter and sustenance) means that these needs are often ignored and left undiagnosed. The findings of this health snapshot suggests that there is an ongoing need for the provision of more proactive and co-ordinated primary health care services to meet the needs and to direct people who are homeless to the most appropriate source of health support needs.

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Appendix 1. A breakdown of Physical Health Conditions by Accommodation Type

Diagnosed Physical Health Conditions	Current accommodation type														
	B&B	**Emergency Accommodation**	**High Support Housing**	**Local Authority - with no support**	**Local Authority - with visiting support**	**Low Support Housing**	**Medium Support Housing**	**Owner Occupier**	**Private Rented - with no support**	**Private Rented - with visiting support**	**Residential Rehab/ Detox**	**Rough Sleeping**	**Social Housing - with visiting support**	**Squat**	**Transitional Accommodation**
Cirrhosis (Liver Disease)	0	4	13	0	1	0	1	0	0	0	3	3	1	0	0
Haemorrhoids	0	0	0	2	0	5	0	0	1	0	1	0	0	0	0
Jaundice	0	1	0	0	0	0	0	2	0	0	0	0	0	0	0
Pressure Sores	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Anaemia	0	2	1	1	3	3	0	1	2	1	2	0	3	0	1
Conjunctivitis	0	1	1	0	0	0	1	0	0	0	0	0	1	0	0
Hardened Arteries	0	0	0	0	0	0	1	0	0	1	0	0	2	0	0
Kidney Infection	0	8	2	1	5	3	2	1	0	0	0	0	2	0	0
Psoriasis	0	4	2	0	0	2	0	1	0	0	0	0	1	0	0
Angina	0	1	8	0	1	2	2	1	0	1	1	0	0	0	0
Constipation	0	2	0	0	1	3	1	1	0	0	0	0	1	0	0
Head Injury*	0	8	7	1	2	2	0	3	2	0	0	2	2	0	0
Acquired brain injury	0	1	3	0	0	0	0	1	1	0	0	0	0	0	0
Arthritis	1	5	10	6	7	2	0	0	0	0	3	0	2	0	0
Cuts & Bleeding	0	7	12	2	1	4	1	3	2	1	0	2	1	0	0
Head Lice	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0
Migraine	2	8	5	3	0	1	1	0	1	0	0	0	6	0	0
Sexual Health	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0
Asthma	1	17	13	2	7	4	0	0	2	1	3	4	7	0	2
Deafness &	0	3	3	2	3	7	1	1	2	3	0	0	3	0	0

Hearing Problems															
Hepatitis A	0	2	0	0	1	2	1	1	1	0	0	0	0	0	0
Minor Stroke	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0
Slipped Disc	0	2	3	0	0	3	0	0	0	0	0	0	2	0	0
Broken bones	0	12	11	3	5	0	1	1	0	0	3	3	1	0	0
Dental Conditions	0	12	29	4	13	2	2	1	3	0	5	5	8	0	1
Hepatitis B	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0
Motor Neuron Disease	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Spinal Muscular Atrophy	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0
Cancer	0	3	2	1	0	0	1	1	0	0	0	0	0	0	0
Developmental Amnesia	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Hepatitis C	1	19	11	0	2	0	1	0	2	4	1	6	3	0	0
Multiple Sclerosis	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Tuberculosis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Bronchitis	0	4	2	4	2	0	0	0	0	1	0	1	1	0	0
Acute Bronchitis	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0
Chronic Bronchitis	0	0	1	1	1	0	0	0	1	0	0	0	0	0	0
Urinary Tract Infection	0	2	1	0	0	1	0	0	0	0	0	1	1	0	0
Cardiovascular Disease	0	2	9	0	3	2	1	0	0	0	0	0	0	0	1
Diabetes	0	3	6	4	4	2	3	1	1	0	0	0	1	0	0
Hernia	0	0	5	1	2	6	2	2	1	2	0	1	1	0	0
Muscular Dystrophy	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Varicose Veins	0	1	1	2	3	0	1	1	0	0	0	0	0	0	0
Cataracts	0	1	0	0	0	1	0	1	0	0	0	0	0	0	0
Epilepsy	0	13	8	1	3	3	1	1	0	1	0	2	4	0	0
High Blood Pressure	1	13	9	1	6	4	3	3	0	1	2	0	4	0	0

Osteoporosis	1	1	0	1	2	1	1	0	0	0	0	0	0	0	0
Vertigo	0	0	0	1	1	0	0	2	0	1	0	0	0	0	0
Cerebral Palsy	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Gallstones	0	2	0	1	0	2	0	0	0	1	0	0	1	0	0
HIV	0	1	4	0	0	1	0	0	0	1	0	1	0	0	0
Parkinson's Disease	0	0	2	0	0	1	0	1	0	0	0	0	0	0	0
Chiropody Conditions	0	2	20	0	0	0	2	1	1	0	0	1	1	0	0
Gangrene	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Peptic Ulcer	0	4	2	1	0	0	1	2	1	1	0	0	1	0	0
Wet Brain***	0	4	3	0	0	0	0	0	1	0	0	0	1	0	0
Chronic Fatigue Syndrome	0	0	2	1	1	0	1	0	0	1	0	0	0	0	0
Gastroenteritis	0	2	1	1	3	1	0	0	1	1	0	1	2	0	0
Incontinence	0	2	7	1	3	0	1	1	0	0	0	1	1	0	0
Pleurisy	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0
Pulmonary Disease (COPD)	0	2	3	0	3	1	0	0	0	2	0	0	0	0	1
Glaucoma	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Irritable Bowel Syndrome	0	0	1	1	3	3	1	0	1	0	0	0	2	0	0
Pneumonia	0	5	2	3	0	4	0	1	0	0	0	0	0	0	0
Total No of Physical Health Conditions	7	189	234	56	94	83	35	36	28	25	25	37	68	0	6
Total No of Respondents who lived in this accommodation type	4	140	118	26	56	57	39	13	16	24	12	29	43	2	10
Average no of Physical health conditions per respondent	1.8	1.3	2.0	2.15	1.7	1.5	0.9	2.8	1.8	1	2.0	1.3	1.6	0	0.6

Appendix 2 A Breakdown of Mental Health Conditions by Accommodation Type

Diagnosed Mental Health Conditions	Current Accommodation Type														
	B&B	**Emergency Accommodation**	**High Support Housing**	**Local Authority - with no support**	**Local Authority - with visiting support**	**Low Support Housing**	**Medium Support Housing**	**Owner Occupier**	**Private Rented - with no support**	**Private Rented - with visiting support**	**Residential Rehab/Detox**	**Rough Sleeping**	**Social Housing - with visiting support**	**Squat**	**Transitional Accommodation**
Binge Eating	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0
Panic Attacks	0	9	7	0	3	5	1	3	1	1	0	1	3	0	1
Social Anxiety Disorder	0	3	7	1	4	5	1	0	1	0	0	0	4	0	2
Dementia	0	1	1	0	0	0	0	0	1	0	0	1	1	0	0
Delusional Disorder	0	3	2	0	0	0	0	0	1	0	0	1	1	0	0
Phobias	0	1	3	0	2	0	1	1	0	1	0	0	0	0	0
Substance Induced Psychotic Disorder	0	5	6	0	1	0	0	0	0	1	0	2	0	0	1
Anorexia Nervosa	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0
Bipolar Disorder	0	4	10	0	3	2	6	1	1	0	0	0	3	0	0
Depression	1	40	33	4	17	25	10	7	3	12	7	2	11	0	3
Post Traumatic Stress Disorder	0	1	1	0	0	2	0	1	3	0	0	0	1	0	0
Brief Psychotic Disorder	0	7	1	0	0	1	2	0	0	0	0	0	1	0	0
Borderline Personality Disorder	0	8	8	0	1	5	0	0	2	0	0	0	1	0	0
Obsessive Compulsive Disorder	0	2	5	1	1	1	3	1	0	3	0	0	2	0	0
Schizophrenia	0	10	21	1	2	6	3	0	0	0	0	1	5	0	1
Seasonal Affective	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0

Disorder (SAD)															
Other	0	1	3	0	2	2	1	0	0	1	0	1	3	0	0
	1	971	108	8	37	55	28	15	13	19	7	9	37	0	8
Total No of Respondents who lived in this accommodation type	4	140	118	26	56	57	39	13	16	24	12	29	43	2	10
Average No of Physical health conditions per respondent	0.3	0.7	0.9	0.3	0.7	1.0	0.7	1.2	0.8	0.8	0.6	0.3	0.9	0.0	0.8