



## *Homelessness and Health*

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### **Opening Statement to the Oireachtas Committee on Health from the Simon Communities in Ireland**

*5<sup>th</sup> July 2017*

## 1. Introduction

**1.1 Thank you and about the Simon Communities:** Thank you to the Committee and the Chairperson for inviting us here today: The Simon Communities are a network of communities, providing local responses to local needs and issues of homelessness all around the country based in Cork, Dublin, Dundalk, Galway, the Midlands, the Mid West, the North West and the South East. As the Committee members will be aware, the complexity of homelessness touches every facet of Irish life with the greatest impact being felt by those most vulnerable in society. We welcome the opportunity to speak to you today to illustrate further the complexity of issues and needs facing people experiencing homelessness.

**1.2 Homelessness and health – the links:** There is a complex relationship between homelessness and health incorporating physical health issues, mental health issues, problematic drug and alcohol use and complex needs. Health issues can be the cause of homelessness occurring in the first place but they can also be a consequence of the experience of being homeless. What is clear is the longer a person is homeless the greater the impact on their overall health and wellbeing. People experiencing homelessness are not a homogenous group. They are a diverse group of people that include women, young men, families, those with complex mental and physical health needs and people with problematic drug and alcohol use. Understanding this diversity and individual's unique pathways into and experiences of homelessness is crucial to ensure we can respond to their individual and often complex health needs.

## 2. Health and Homelessness

**2.1 Physical health:** The lack of a stable home can cause poor physical health. People who are homeless are more at risk of developing an illness than the general population.

A recent study on the health of homeless people by the Partnership for Health Equity '*Homelessness: An Unhealthy State*' found that 67.8% of participants in the study had a chronic physical health diagnosis, such as diabetes, high blood pressure, arthritis, heart disease, epilepsy, tuberculosis, and chronic respiratory & stomach problems.<sup>1</sup>

Blood borne viruses such as hepatitis and HIV are also high among people who are homeless and they are more at risk of contracting one of these diseases. A recent study by the Royal College of Surgeons in Ireland and Doctor Austin O'Carroll of Safetynet Dublin, '*Health and use of health services of people who are homeless and at risk of homelessness who receive primary healthcare in Dublin*' further supports these findings.<sup>2</sup>

**2.2 Mental health:** Mental health issues can be a reason for people becoming homeless in the first place while the experience of being homeless can affect a person's mental health, deteriorating the longer a person remains homeless.

*Homelessness: An Unhealthy State* reports 58% of participants had at least one mental health condition. Of a sample size of 596 participants,

- 52% were diagnosed with depression with 44% being treated for their depression.
- 39% percent of respondents were diagnosed with anxiety with 32% receiving treatment.
- 13.4% of participants had self-harmed in the past 6 months while 24.7% had self-harmed prior to the past six months.

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<sup>1</sup> O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) *Homelessness: An Unhealthy State*. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity. <http://www.healthequity.ie/#/report-launch/iuv63>

<sup>2</sup> <http://epubs.rcsi.ie/cgi/viewcontent.cgi?article=1079&context=gpart>

- 29% percent of participants had attempted suicide in the past six months while 28% had attempted suicide prior to the past six months. In acknowledgement of this, the National Office for Suicide Prevention 2020 strategy highlights people who are homeless as a priority group.

**2.3 Problematic drug and alcohol use:** Problematic drug and/or alcohol use can put people at an increased risk of homelessness, and can also be caused and/or exacerbated by traumatic experiences, including homelessness.

The *Homelessness: An Unhealthy State* report found there was a rise among participants in problematic drug and alcohol use in particular, as well as a dramatic rise in dangerous drinking among women who were homeless, a rise in illicit use of benzodiazepines, while poly-drug use among participants became the norm with a high use of prescribed sedatives. Cannabis was the drug most commonly used among current drug users followed by illicit use of benzodiazepines and heroin.

Some of the Simon Communities have seen an increase in the use of opiate drugs, prescription drugs (in particular, benzodiazepines) and synthetic benzodiazepines drugs. A Simon Communities Snapshot Study Report found that over 50% of respondents reported that they were current alcohol users, while 31% reported that they were current drug users.<sup>3</sup>

That health snapshot study found that alcohol use was highest among respondents living in high-support housing and emergency accommodation. The snapshot study also found the highest level of drug use was among people sleeping rough and those using emergency accommodation.

**2.4 Dual diagnosis and complex needs:** A person who is homeless may have multiple needs or complex needs<sup>4</sup>, such as problematic drug and/or alcohol use, mental health difficulties, physical health difficulties, personality or behavioural disorder, challenging behaviour and vulnerability. This makes it very difficult for people to be in contact with all the various services they may need at one time. If one issue were to be resolved, other issues would still be cause for concern (Homeless Link, 2002)<sup>5</sup>.

The *Homelessness: An Unhealthy State* report found that 47% of participants had a mental health diagnosis and a self-diagnosed drug and/or alcohol problem. Thirty-five percent of participants had a mental health diagnosis and current illicit drug use. People with dual diagnosis can find it very difficult to access services. They often fall between two stools with mental health services suggesting they deal with their drug issue first and vice versa. International best practice argues that the two issues be treated at the same time and in a co-ordinated way.

**2.1 Barriers to accessing healthcare for people experiencing homelessness:** People who are homeless and those that provide services for people who are homeless have reported many challenges that they face when trying to access services. Cutbacks in health and HSE budgets since the onset of the financial crisis have had a detrimental impact on access to services. Many people who are homeless only access health services when they are in crisis or when illness is well developed and severe, a point at which they access health care through

<sup>3</sup> Simon Communities in Ireland & Kathy Walsh, *'Simon Snapshot Report 2011'*, P.28,

<http://www.simon.ie/Portals/1/Simon's%20National%20Health%20Snapshot%20Study%20Report%202011.pdf>.

<sup>4</sup> A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing (Turning Point, 2014) [http://www.turning-point.co.uk/media/636823/appg\\_factsheet\\_1\\_-\\_june\\_2014.pdf](http://www.turning-point.co.uk/media/636823/appg_factsheet_1_-_june_2014.pdf)

<sup>5</sup> As cited in Feansta Health Working Group paper (2013) *'Health and Well-Being for All Holistic Health Services for People who are Homeless'*.

emergency departments at significant cost.<sup>6</sup> Other barriers to healthcare services include stigma, restrictive catchment areas for drug treatment and detox services, inflexibility of services, lack of discharge protocols, lack of specialised services, lack of case management teams and the relative dearth of services in rural settings.

### 3. Solutions

**3.1 Housing First:** Housing First programmes are internationally considered to represent best practice in housing people who are long term homeless with complex needs. People with physical health, mental health, dual diagnosis and complex needs often remain trapped in homelessness.

Housing First offers housing without preconditions and offers a range of supports focussed on harm minimisation, trauma informed care and supporting recovery and empowerment through Assertive Community Treatment (ACT) teams. The success of such initiatives depends not just on housing but also, crucially, on drug and/or alcohol, mental health, and community integration services being available to tenants who were formerly homeless.

There are two key aspects to the Housing First<sup>7</sup> approach - immediate provision of housing without pre-conditions or the requirement of housing 'readiness' and the provision of open ended, support in housing at the level required, for as long as necessary. Clinical supports are a central component of the wider Housing First support system. The recovery oriented approach to clinical supports is designed to enhance well-being, mitigate the effects of mental health and addiction challenges and improve quality of life and foster self-sufficiency.<sup>8,9,10</sup>

**3.2 Health:** Increase access to general practitioner (primary healthcare) services to meet the healthcare needs of people who are homeless and to provide early intervention to prevent further chronic illness.

Ongoing resourcing for primary care services and interventions in homeless services where required nationwide. . There are some excellent examples of such initiatives in operation in the Simon Communities.

Resource the delivery of step up/step down beds for people who are homeless being treated for chronic illness.

**3.3 Mental Health:** Fill essential posts in mental health services to ensure nationwide coverage of Community Mental Health Teams with a clear identification of CMHT team with responsibility and accountability for people who are homeless in each catchment area. CMHT to be equipped to offer assertive outreach.

<sup>6</sup> O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity. <http://www.healthequity.ie/#!report-launch/iuv63>

<sup>7</sup> In 2014 research undertaken by Mental Health Commission of Canada as part of the *At Home/Chez Soi* study, the largest ever study examining the effectiveness of the Housing First approach compared with the traditional staircase approach. The study followed more than 2,000 people who were homeless over a two-year period across five Canadian cities. The findings were very clear: The Housing First intervention was twice as effective as the staircase approach in ending homelessness for people who had been long-term homeless with complex support needs. Furthermore, the intervention led to significant cost savings when compared with traditional interventions<sup>7</sup>. The key to the success of Housing First is its comprehensive model of support for the most 'hard core' people who are homeless with the highest level of needs.

<sup>8</sup> Nicholas Pleace, European Observatory on Homelessness/FEANTSA, *'Housing First'*, P. 22, [http://www.feantsaresearch.org/download/housing\\_first\\_pleace3790695452176551843.pdf](http://www.feantsaresearch.org/download/housing_first_pleace3790695452176551843.pdf).

<sup>9</sup> Montgomery A.E., Hill L., Culhane D.P., Kane V., *'Housing First Implementation Brief'*, P. 5, VA National Center on Homelessness Among Veterans/U.S. Department of Veterans Affairs, 2014, <https://www.va.gov/homeless/nchav/docs/Housing-First-Implementation-brief.pdf>.

<sup>10</sup> Calgary Homelessness Foundation, *'The Cost Benefits of Housing First'*, <http://calgaryhomeless.com/wp-content/uploads/2014/06/The-Cost-Benefits-of-Housing-First.pdf>.

Develop 'Specialist Adult Teams' to manage the combination of complex and problematic drug and alcohol use and mental health issues as recommended in 'A Vision for Change' and the 'National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self Harm' and ensure interagency responses.

Increase funding for mental health services to 8.24% of the national health budget as recommended in 'A Vision for Change'. This should include the dedicated ring fencing of funding streams for the full implementation of the commitments contained in 'A Vision for Change'.

The proposal in the *Implementation Plan on the State's Response to Homelessness* to provide a dedicated Community Mental Health Nurse in each ISA10 area to support the needs of people who are homeless or at risk of homelessness needs to be actioned.<sup>11</sup> This is supported in the *Report of the Committee on Housing and Homelessness* (2016).<sup>12</sup>

Trauma informed practices and counselling services should be prioritised including greater resourcing of social work, community and family services as a means of reducing the prevalence of problematic use and earlier drug taking by those that have experienced adverse traumatic experiences in childhood. Residential treatment centres should be resourced to address post-traumatic stress disorder concurrently with addiction treatment given an estimated prevalence rate of 66% amongst residential treatment participant and onsite counselling/psychological services developed in homeless accommodation services to provide trauma informed care.

All HSE funded residential treatment services should be upskilled to manage dual diagnosis cases as a basis of best practice care.

**3.4 Harm Reduction:** Harm reduction is a set of policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs'.<sup>13</sup> Harm reduction must be at the heart of homeless and drug service provision and is key to the success of Housing First approaches. Greater expansion of current harm reduction programmes and strategies is required to ensure people with problematic drug use and the associated complex physical and mental health needs can get the help they require.

Greater consideration must also be given to the introduction of harm reduction strategies that have had a positive impact in other jurisdictions. The recent passing of legislation to establish the State's first Medically Supervised Injecting Centres is welcome, implementation must be expedited to have an impact quickly.

Greater expansion of and access to needle exchange programmes is required across static, outreach and pharmacy exchange models.

At a time when de-criminalisation is being explored in Ireland there is a unique opportunity to shift policing focus from individual users and intensify efforts on suppliers.

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<sup>11</sup> Implementation on the State's Response to Homelessness, May 2014 to December 2016,

<http://www.housing.gov.ie/sites/default/files/migrated-files/en/Publications/DevelopmentandHousing/Housing/FileDownload%2C38053%2Cen.pdf>.

<sup>12</sup> Report of the Committee on Housing and Homelessness, June 2016,

<http://www.oireachtas.ie/parliament/media/committees/32housingandhomelessness/Final-Report.pdf>.

<sup>13</sup> Harm Reduction International, 'What is Harm reduction – A Position Statement from Harm Reduction International', <https://www.hri.global/what-is-harm-reduction>.

**3.3 Treatment:** Alcohol and drug services must be resourced nationally to target the needs of people who are homeless with alcohol and/or drug related problems in line with the four tier model. This should include rapid access to substitution treatment, detoxification, rehabilitation/recovery and aftercare countrywide and include all substances. Access to aftercare housing is particularly important for homeless persons exiting treatment, given the high risk of relapse in traditional homeless services settings.

Rapid access to treatment is essential. People who are homeless often have to wait in homeless services until a treatment place becomes available. This in itself can make adherence to access criteria unrealistic for many homeless clients given their proximity in homeless services to substances and their inability to avoid triggers.

**3.5 Rehabilitation:** There needs to be an outline of specific actions to address the rehabilitation needs of people who are homeless with addiction issues as committed to in the Rebuilding Ireland Action Plan.

Develop, resource and implement discharge protocols and in-reach services for general hospitals, mental health services and drug treatment services for people who are homeless in conjunction with primary care networks and local primary care teams. Nobody should be discharged back into homelessness.

Ensure that ring-fenced emergency accommodation options are in place for drug users experiencing homelessness when they are detoxing, working towards methadone maintenance or are trying to abstain from drug/alcohol use. This is a short term measure to facilitate the wider rollout of Housing First tenancies and the provision of in-house drug treatment and rehabilitation services.

**3.6 Report of the Oireachtas Committee on the Future of Healthcare:** We fully support the findings of the Report of the Oireachtas Committee on the Future of Healthcare, particularly the proposed expansion of primary health and mental health care services in the community. The expansion of counselling services to primary care facilities would allow people with mental health needs to get the right healthcare intervention at the right time, reducing the need to access other more acute/crisis mental health services. This would have a significant impact on those experiencing homeless and those at risk of homelessness given the stress and trauma associated with these experiences. The proposal to introduce universal access to primary care must be a continued priority of the Department of Health and the State. In the interim period capacity building of general practice, primary and social care services must be pursued to provide timely and quality care at the lowest level of complexity.

**3.5 Forthcoming National Drug Strategy:** We look forward to specific commitments in relation to people who are homeless, harm reduction, treatment and rehabilitation in the forthcoming National Drug Strategy. We made a submission to the process of developing the new NDS which we can share with committee members.<sup>14</sup>

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<sup>14</sup> Simon Communities in Ireland, Submission to Inform the National Drug Strategy, October 2016, <http://www.simon.ie/Portals/1/Simon%20Communities%20in%20Ireland%20Submission%20to%20inform%20the%20National%20Drug%20Strategy.pdf>.

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#### 4. Conclusion

People who are homeless can experience a range of health issues, which include but are not limited to, physical health issues, mental health issues, problematic drug and alcohol use and complex needs. People presenting to homeless services often display multiple or complex needs within these broad health categories. The prevalence of illness amongst people who are homeless is exacerbated by a lack of good quality housing and the absence of clinical and health supports in the home. People who are homeless often encounter other significant barriers to healthcare in the form of stigma, cuts to health/HSE budgets, administration of service catchment areas and the lack of homeless specialist health services. Best practice indicates that improving access to primary care services has large-scale health benefits for people who are homeless in addition to cost saving implications for the health service as a whole. The solutions to homelessness involve preventing people from becoming homeless and providing access to affordable, permanent housing with support, as necessary (Housing First). Critical to this is the provision of clinical support. We know this approach works and we know that it can transform the lives of people who are living in hostels, hotels and B&B's. We believe the work of the Committee can have a beneficial impact on the improvement of existing health services for people who are homeless and the delivery of future services that specifically target the myriad of homeless specific health issues identified in this submission.

**About Simon Communities**

The Simon Communities in Ireland are a network of eight regionally based independent Simon Communities based in Cork, Dublin, Dundalk, Galway, the Midlands, the Mid West, the North West and the South East that share common values and ethos in tackling all forms of homelessness throughout Ireland, supported by a National Office. The Simon Communities have been providing services in Ireland for over 40 years. The Simon Communities deliver support and service to over 8, 300 individuals and families throughout Ireland who experience – or are at risk of – homelessness every year.

Whatever the issue, for as long as we are needed, Simon's door is always open. For more information, please visit [www.simon.ie](http://www.simon.ie)

**Services include:**

- Housing provision, tenancy sustainment & settlement services, housing advice & information services helping people to make the move out of homelessness & working with households at risk;
- Specialist health & treatment services addressing some of the issues which may have contributed to homeless occurring or may be a consequence;
- Emergency accommodation & support providing people with a place of welcome, warmth & safety;
- Soup runs & rough sleeper teams who are often the first point of contact for people sleeping rough.

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**Appendix 1: Housing and homelessness crisis in numbers**

- During one week in May 2017 (latest available figures), there were 7,699 men, women and children in emergency accommodation across the country. This included 3,150 adults with no dependents in their care and 1,312 families with 2,777 children. (DHPCLG, May 2017).
- On the night of 22<sup>nd</sup> November 2016, there were 142 people without a place to sleep in Dublin City. This included 65 people sleeping rough and 77 people sheltering at the Nite Café. Unfortunately, Dublin is the only area where an official rough sleeper count takes place, making it difficult to get a countrywide rough sleeping picture. (DRHE 2016).
- Homelessness and housing insecurity are more acute and visible in our cities but the Simon Communities are working at capacity countrywide – in urban and rural areas.
- There are 91,600 households on the social housing waiting list. Two-thirds of households on the list were living in the private rented sector and one fifth living with parents, relatives or friends. 5,159 households (5.6%) had at least one member considered to be homeless, a proportion which has doubled since 2013 (Housing Agency, 2016).
- Social housing commitments will take time to begin to deliver housing. This is far too long for the people we work with and those at risk of homelessness. In 2016, just 665 new social housing units were built.
- Average national rent now stands at €1,131, representing an increase of 52% since 2012. Property availability in the private rented sector has dropped by 82% since 2012 with fewer than 3,100 properties available to rent nationwide on May 1<sup>st</sup> 2017. (Daft.ie Rental Report Q1 2017).
- *Locked Out of the Market VII* (May 2017 Simon Communities) found that 88% of rental properties are beyond the reach for those in receipt of state housing support.
- Over 76,000 principle dwelling mortgage accounts are in arrears. 43% of all mortgage arrears are in arrears of over 720 days (Central Bank of Ireland, May 2017).
- At the end of March 2017, 20,009 or 16% of buy-to-let mortgages, were in arrears of more than 90 days. (Central Bank of Ireland, May 2017).
- 750,000 people are living in poverty in Ireland (*Poverty, Deprivation and Inequality* (July 2016) Social Justice Ireland Policy Briefing).
- Since 2007 the deprivation rate, which looks at the number of people forced to go without at least 2 of 11 basic necessities examined, in Ireland has doubled - 29% of the population or 1.3 million people are experiencing deprivation (Social Justice Ireland *ibid*).
- According to Census 2016, there are 183,312 vacant houses nationwide.