

Homelessness, health and drug use in Dublin City

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Report Summary

An increase in the number of cases of recently acquired HIV in persons who inject drugs (PWID) was identified in Dublin in 2015. A case control study, led by the Health Protection Surveillance Centre (HPSC), identified a number of factors which appeared to have contributed to this upsurge, including the use of the drug ‘Snow Blow’ and risky sexual and injecting practices. In addition, epidemiological investigation demonstrated that 74.4% of cases had been registered with homeless accommodation services since January 2014; this included 93.8% of cases in women. These findings prompted this review of homelessness and health in Dublin, with specific emphasis on PWID.

In July 2015, Dublin City Council reported that there were 21,592 outstanding applications on the social housing waiting list – the highest ever recorded. There was a 28% increase in the number of individuals accessing emergency accommodation in Dublin in the twelve months to June 2015. The number of families accessing emergency accommodation increased by 43% between January and June 2015. Despite additional capacity being made available following the Government’s Summit on Homelessness in December 2014, Dublin Region Homeless Executive has reported that all available emergency beds for the homeless population in Dublin are filled each night as demand for services has continued to grow. Therefore, it is clear that the homeless situation in Dublin deteriorated significantly in 2015 and continues to do so.

The prevalence of blood borne viruses among the homeless population in Dublin can be estimated from the results of a survey of over 500 participants in 2013; 3.6% were HIV positive, with 4.8% and 28.5% having diagnoses of hepatitis B and C, respectively.

Four studies, between 1997 and 2013, used a similar methodology to assess the health of the homeless population in Dublin, thereby allowing comparisons over time;

- The proportion of respondents with at least one physical or mental health diagnosis increased from 68% in 1997 to 89.6% in 2013.
- The proportion of those who had become homeless primarily as a result of drug and/or alcohol addiction increased from 23.8% in 1997 to 37.9% in 2013.
- The proportion who had ever used drugs increased from 29% in 1997 to almost 80% in 2013.

- The proportion who identified themselves as active drug users increased from 23% of the study cohort in 2005 to 54% in 2013.

The total number of people on the Central Methadone Treatment List (CTL) increased from 5,498 in 1998 to over 11,000 in 2014. Between 1998 and 2014, the percentage on the CTL who were registered as being of no fixed abode increased from 1% (57/5,498) to 7% (766/11,206). It increased from 2% (184/10,711) to 7% between 2011 and 2014 alone (Figure 4). In May 2015, a total of 534 persons with no fixed abode, but located in Dublin, were recorded on the CTL.

Data from the National Self Harm Registry Ireland demonstrated that the proportion of presentations recorded by the Registry in people who were homeless increased from 3% in 2007 to 5% in 2014. The absolute number of presentations increased by 49% between 2007 (n=344) and 2014 (n=514). This increase was more pronounced among women (+68%).

The number of drug- and alcohol-related deaths among those who resided in Dublin increased by 41% from 2004 (n=419) to 2013 (n=590). The number of deaths amongst those identified as homeless and who died in Dublin fluctuated over the time period with an overall upward trend. Twenty two (54%) of the 47 deaths in Dublin in 2013, in those identified as homeless, were directly attributable to poisoning. Of these, 17 (77%) involved polydrug use. Opiates were implicated in 21 (95%) of the deaths.

This report makes a number of recommendations including the need for improved coordination between agencies tasked with addressing the health and social care needs of the homeless. Pragmatic interventions, which recognise the reality of injecting drug use in hostels and the pressures which that reality places on both staff and service users, are proposed.

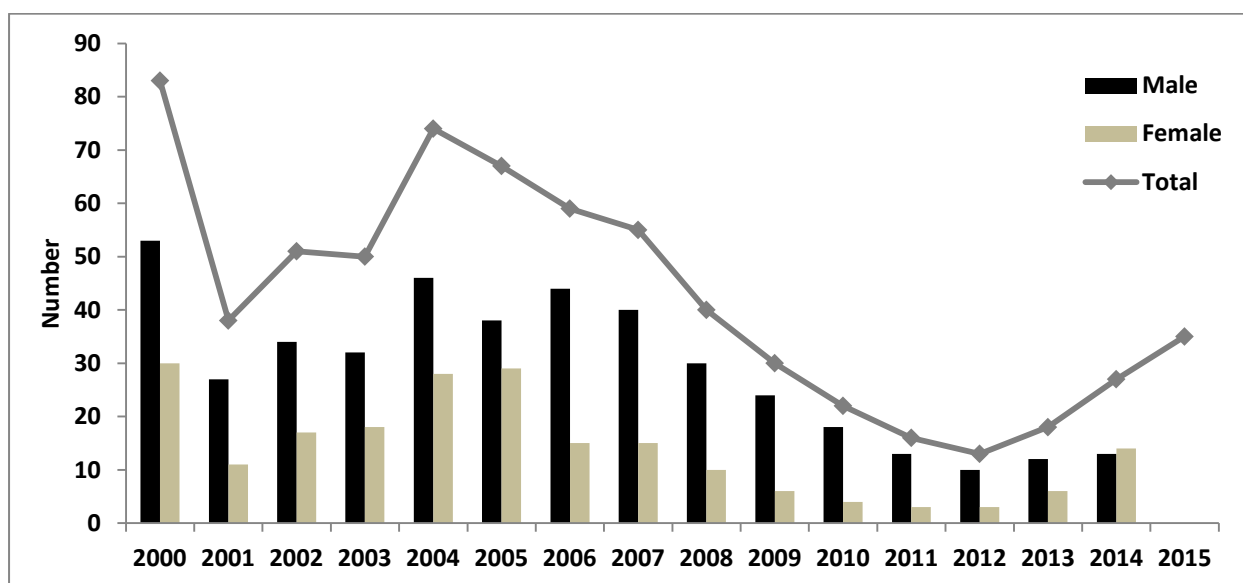
1 Background

The Dept of Public Health HSE East is investigating a rise in the number of cases of recently acquired HIV in persons who inject drugs (PWID) in Dublin in 2015.

Between January 2014 and 31st October 2015 33 confirmed, six probable and 15 possible (which remain under investigation) cases of HIV in PWID were reported. The number of confirmed and probable cases steadily increased from September 2014 and peaked in February 2015, with half of the cases reported in the first seven months of 2015.

This increase in the number of new diagnoses of HIV among PWID is in the context of a year on year increase in notifications since 2012. In 2014, there were 27 (7%) new diagnoses among PWID - the highest number reported since 2009 (Figure 1.1). Of these, 89% (n=24) were co-infected with Hepatitis C. 41% of PWID newly diagnosed with HIV in 2014 were infected in either 2013 or 2014. 89% (n=24) were resident in HSE East at the time of diagnosis. 85% were born in Ireland.(1)

Figure 1.1 Notifications of HIV among PWID, 2000-2015*



*The 2015 figure is provisional and unverified, and is the total to the end of week 43 2015 only.

Among the confirmed and probable cases (n=39), 17 (44%) were females and the mean age was 35 years (24-51). Of the 39 cases, 30 (77%) had been registered with homeless accommodation services since January 2014; this included 100% of the female cases. Of 20

who provided the information, 18 (90%) reported having used the drug 'Snow Blow'. Twenty three cases (59%) reported engaging in at risk sexual practices.

A case control study, led by the Health Protection Surveillance Centre (HPSC), included 15 cases and 39 controls (attending a drug treatment centre but HIV negative). This identified a number of factors which appear to have contributing to this upsurge including the use of the drug 'Snow Blow' and risky sexual and injecting practices. Homelessness was not identified as a differentiating factor between cases and controls, but this was likely due to the high prevalence of homelessness among both groups (50% cases; 64% controls).

A multidisciplinary incident team was lead by the Director of Public Health in Dublin to investigate and respond to the increase in cases of HIV. This response is ongoing, and the team includes public health and HIV Physicians, GPs providing services for drug users and homeless populations, addiction clinicians, clinical virologist and the Health Protection Surveillance Centre (HPSC).

In addition to the case control study described above, epidemiological investigation, including case finding, has been ongoing since March 2015. Other measures taken to characterise the increase in cases have included analysis of urine from cases in order to screen for the presence of new psychoactive Substances (NPS) (by HSE NDTC Laboratory) and phylogenetic analysis of blood samples from cases in order to support and inform the epidemiological investigation (by the NVRL).

Control measures have focused on enhanced surveillance and early identification of cases and their contacts, awareness-raising among stakeholders and the community at risk, increasing access to needle exchange and promoting HIV testing of PWID. Posters and information leaflets have been developed and distributed to outreach workers, HIV and addiction services and NGOs. Pilot point of care testing (POCT) of PWID attending the SafetyNet homelessness services has been trialled and all services have been encouraged to promote testing as appropriate.

2 Trends in accommodation services for the homeless population in Dublin

2.1 Background to housing in Dublin

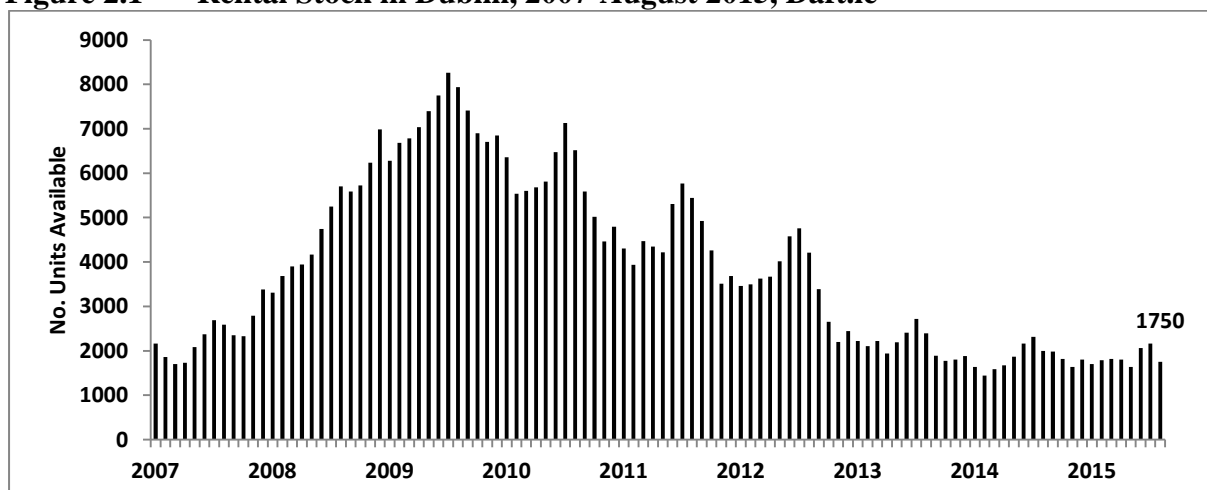
In July 2015, Dublin City Council reported that there were 21,592 outstanding applications on the social housing waiting list. Representing 42,106 people, (25,617 adults and 16,489 children), this was the highest number of outstanding applications ever recorded on this list. Of the 21,592 applicants, almost half, 10,310, have been waiting for between one and five years. The biggest demand in the city is for one-bedroom flats. Some 12,071 people have applied for a one-bedroom home, most of them single (11,075 applicants).

A number of factors have been postulated to have contributed to this increase in applications:

1. Increase in market rent

The number of units available to rent in Dublin on May 1st 2015 was just over 1,600 (quarterly Rental Report by Daft.ie)(2); this was the third lowest reading since reporting started in 2006. At the end of August there were just 1,750 units available to rent (Figure 2.1). Year-on-year inflation in Dublin rents was 6% while that in the commuter counties was 14%.

Figure 2.1 Rental Stock in Dublin, 2007-August 2015, Daft.ie



2. Changes in the Rent Supplement System

Rent Supplement is paid to people living in private rented accommodation who cannot provide for the cost of their accommodation from their own resources. Commencing in 2009, there have been a number of decreases in rent supplement and, in 2013, the Department of Social Protection set Rent Supplement maximum rates at the 35th percentile of availability – i.e. to ensure that 35% of the relevant market is suitably priced for Rent Supplement recipients (3).

3. Lack of Housing

The budget for social housing fell from €1.7bn in 2008 to some €597m in 2014. As noted in the Government's *Social Housing Strategy 2020*, published in November 2014, there is a need for an additional 35,000 properties for social housing (4).

4. Removal of Bed-Sits

New regulations were brought into force in 2013 which outlawed the rental of bed-sits.

2.2 Homelessness Accommodation in Dublin

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.

There are three standard forms of accommodation provided to persons who are experiencing homelessness. They include:

1. Temporary Emergency Accommodation (TEA): providing accommodation for persons with low support needs
2. Supported Temporary Accommodation (STA): providing accommodation with specialist on-site and in-reach support services to bring a person to a point where they are ready to live independently

3. Private Emergency Accommodation (PEA): this includes the use of apartments/ housing/ B&B's sourced by Dublin City Council through the private housing market to ensure a basic response to an emergency presenting need.

The number of adult individuals who were placed in emergency accommodation (TEA, STA & PEA) in Dublin in Q2, 2015 was 3,095, consisting of 2,620 existing or repeat service users and 475 individuals who were new to homeless services (5). An average of 5.2 new people per day required placement over this period. The number of individuals accessing emergency accommodation increased by 28% in the year to June 2015 (Figure 2.2).

In December 2014, the Irish Government organised a 'Summit on Homelessness'. While additional bed capacity was introduced following the Summit, this was largely in the form of 'one-night-only' services. As noted in Figure 3, this additional capacity resulted in an increase in the average number of TEA and PEA placements each night, from an average of 128 placements per night in Q1 2014 to 228 per night in Q1 2015 (Figure 2.3) (5).

Figure 2.2 Number of adult individuals using emergency homeless accommodation each quarter

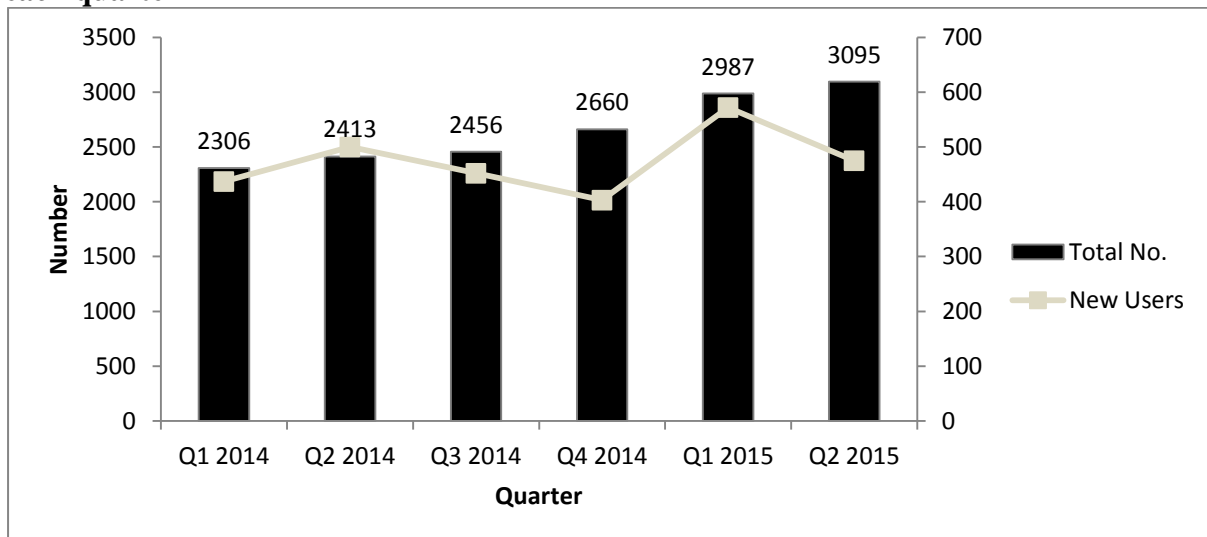
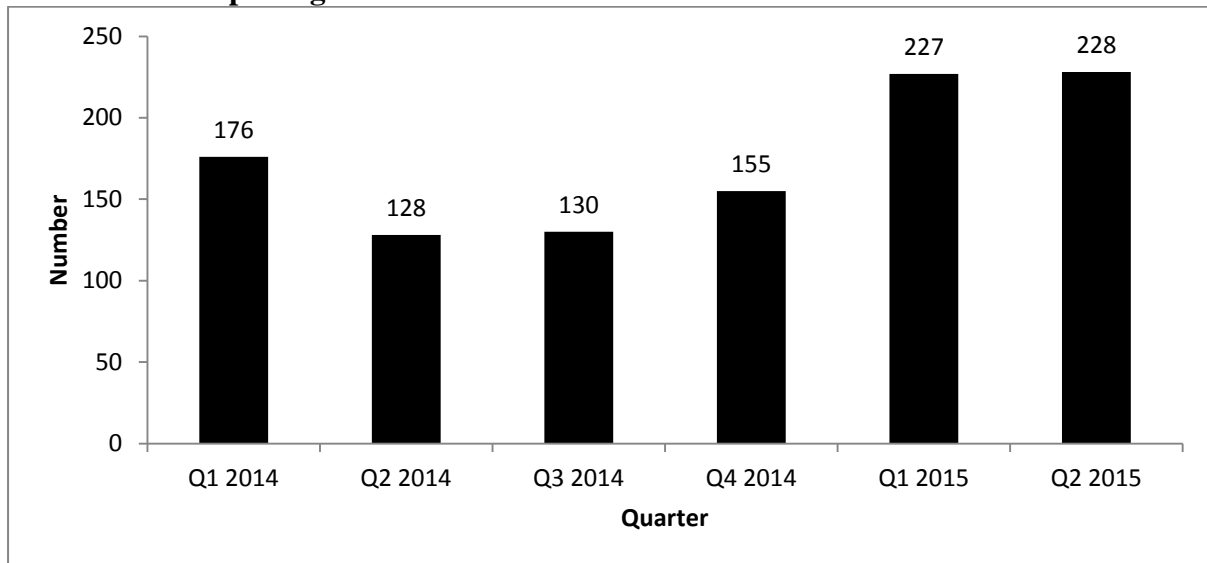


Figure 2.3 Average number of placements (TEA & PEA) in emergency accommodation per night

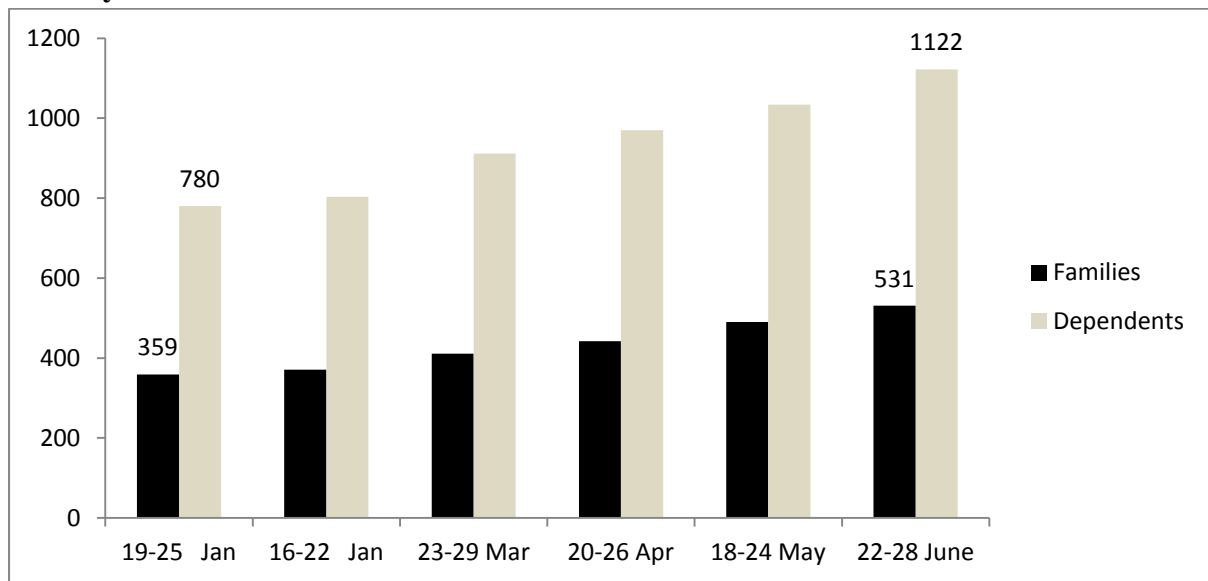


The figures above do not include those individuals who used the Merchant's Quay Night Cafe. This facility was opened in January 2015. It is a supported night service that caters for individuals who choose not to access emergency accommodation or cannot access a bed because services are full. 660 individuals used this service in Q1 2015; 97 of these used the Cafe exclusively and did not engage with accommodation services.

It is noted that, despite the aforementioned additional capacity, all available emergency beds for the homeless population in Dublin are filled each night as demand for services has continued to grow.

The number of adults presenting with child dependents that are new to homeless services increased from 23% of new presenters in Q2 2014 (n=115) to 52% of new presenters in Q2 2015 (n=245) (5). In August 2015, the Department of the Environment, Community and Local Government published its statistics for homelessness in Dublin. These demonstrated a 43.1% increase in the number of families accessing emergency accommodation between January and June 2015 (Figure 2.4).

Figure 2.4 Families and Dependents accessing emergency accommodation in Dublin, January-June 2015



3 Health needs of the homeless population in Dublin

3.1 The Published Evidence

A number of research articles and reports have examined the general health of the homeless population in Dublin over the past 15 years (Table 3.1).

Table 3.1 Publications which have reported on the health of the homeless population in Dublin

First Author	Year Published	Title
Holohan (6)	1997	Health status, health service utilisation and barriers to health service utilisation among the adult homeless population in Dublin
Feeney (7)	2000	The health of hostel-dwelling men in Dublin. Perceived health status, lifestyle and health care utilisation of homeless men in south inner city Dublin hostels
Smith (8)	2001	One hundred homeless women: health status and health service use of homeless women and their children in Dublin
Condon (9)	2001	The health and dental needs of homeless people in Dublin
O'Carroll (10)	2008	Health of the homeless in Dublin: has anything changed in the context of Ireland's economic boom
O' Reilly (11)	2011	Bringing methadone to homeless heroin users
Keogh (12)	2015	Health and use of health services of people who are homeless and at risk of homelessness who receive free primary health care in Dublin
O' Reilly (13)	2015	Homeless, An Unhealthy State

Four of these have used a similar methodology, thereby allowing comparisons over time (6, 10, 12, 13). It should be noted, however, that the same people were not surveyed each time, and hence the comparisons made below are for descriptive purposes only.

3.2 Socio-Demographics

The respondents to the 1997 and 2005 surveys were adults living in emergency or transitional hostels and bed and breakfasts in Dublin (the 2005 study focused on the north side of the city only). Similarly, respondents to the 2013 survey were predominantly those in STA or PEA facilities. In the 2011 survey, 26% of participants were recruited from health clinics and were 'at risk of homeless'. This latter cohort is therefore different to those included in the 1997, 2005, and 2013 surveys and this should be borne in mind in the following discussion.

The characteristics of the respondents to the four surveys are outlined in Table 3.2.

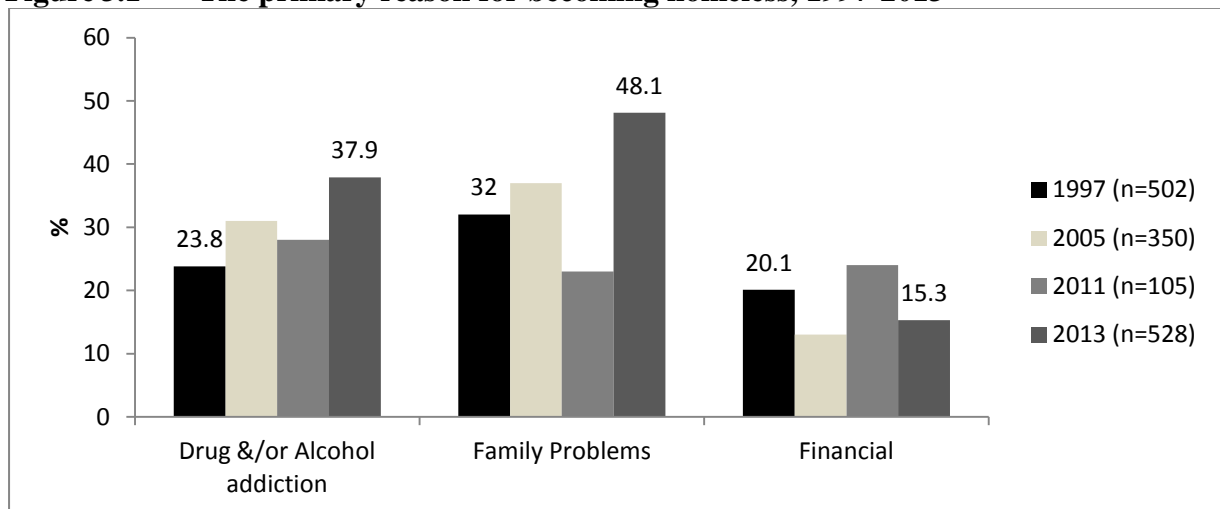
Table 3.2 Publications which have reported on the health of the homeless population in Dublin

First Author	Survey Year	n	'Irish' (%)	Male (%)	Age <45 yrs (%)	'Rough sleeping' (%)	Homeless >12 months (%)
Holohan(6)	1997	502	78	85	64.7	6.2*	44
O'Carroll(10)	2005	350	90	61	81	2*	66
Keogh(12)	2011	105	74	75	69	-	-
O' Reilly(13)	2013	528	87	68	>75	4.3	52

A maximum of 6.2% of respondents reported themselves to be rough sleepers at the time of the survey. The proportion of respondents who had been homeless for greater than 12 months increased from 45% in 1997 to 52.1% in 2013, although this reached a peak in 2005 at 66% and has subsequently declined.

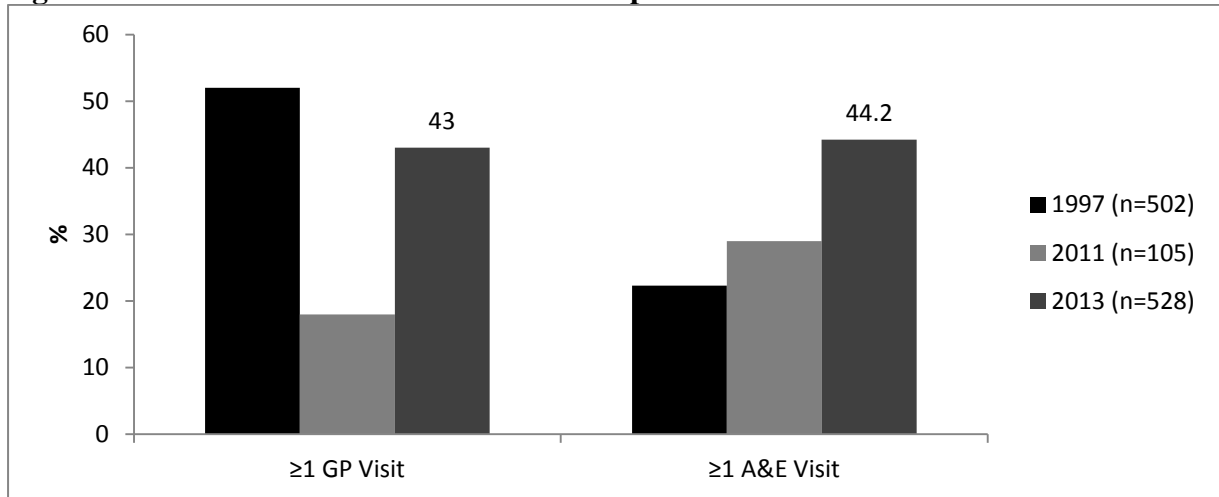
The proportion of those who had become homeless primarily as a result of drug and/or alcohol addiction increased from 23.8% in 1997 to 37.9% in 2013 (Figure 3.1). There were also large increases over time in the proportion of respondents who cited family problems as the primary reason for their homelessness, with almost half of respondents giving this reason in the 2013 study.

Figure 3.1 The primary reason for becoming homeless, 1997-2013



The proportion of respondents with a medical card increased from 55% in 1997 and 2005 to 77% in 2013. The proportion of respondents who had attended a GP at least once in the previous 6 months decreased from approximately 50% in 1997 to 43% in 2013 (Figure 3.2).

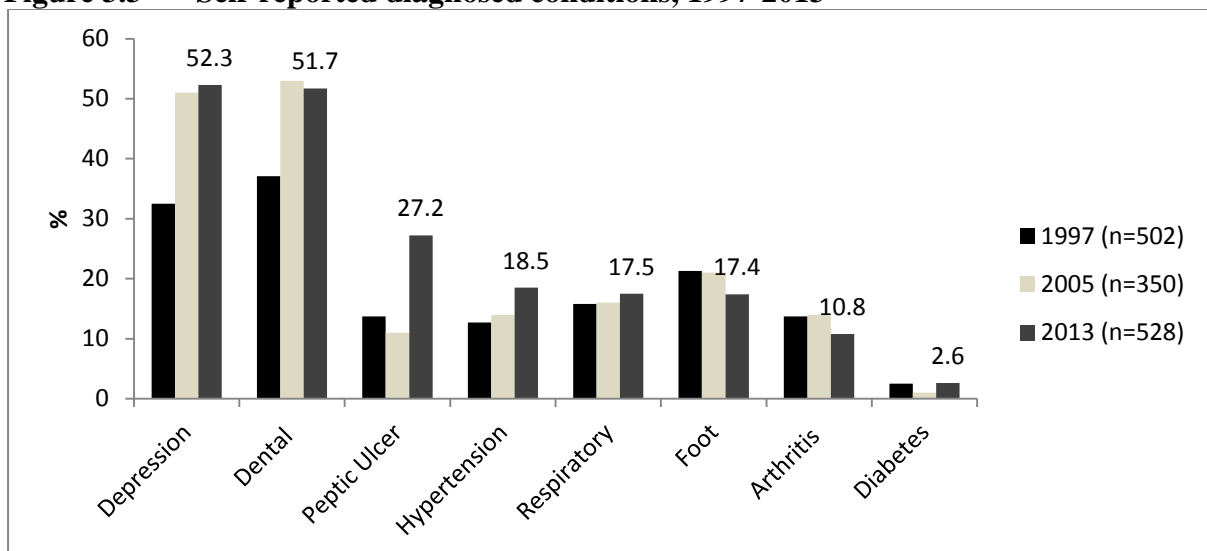
Figure 3.2 GP and A&E attendance in the previous six months



3.3 General Health Status

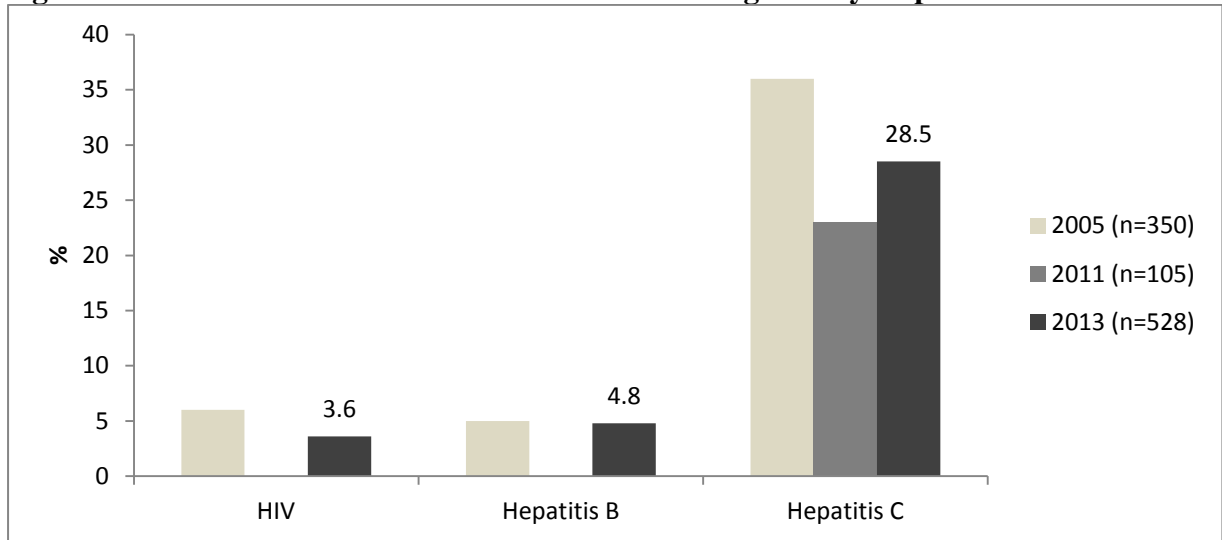
Three studies have provided in-depth descriptive data on the prevalence of diagnosed physical and mental conditions, as reported by the respondent (Figure 3.3). The proportion of respondents with at least one physical or mental health diagnosis increased from 68% in 1997 to 89.6% in 2013. 28.7% of respondents in the 2013 study reported suicidal ideation in the previous 6 months.

Figure 3.3 Self-reported diagnosed conditions, 1997-2013



The prevalence of HIV, Hepatitis B and Hepatitis C were first reported in 2005 (Figure 3.4). The prevalence of HIV was 6% in 2005 and 3.6% in the 2013 study cohort.

Figure 3.4 Prevalence of blood-borne viruses amongst study respondents



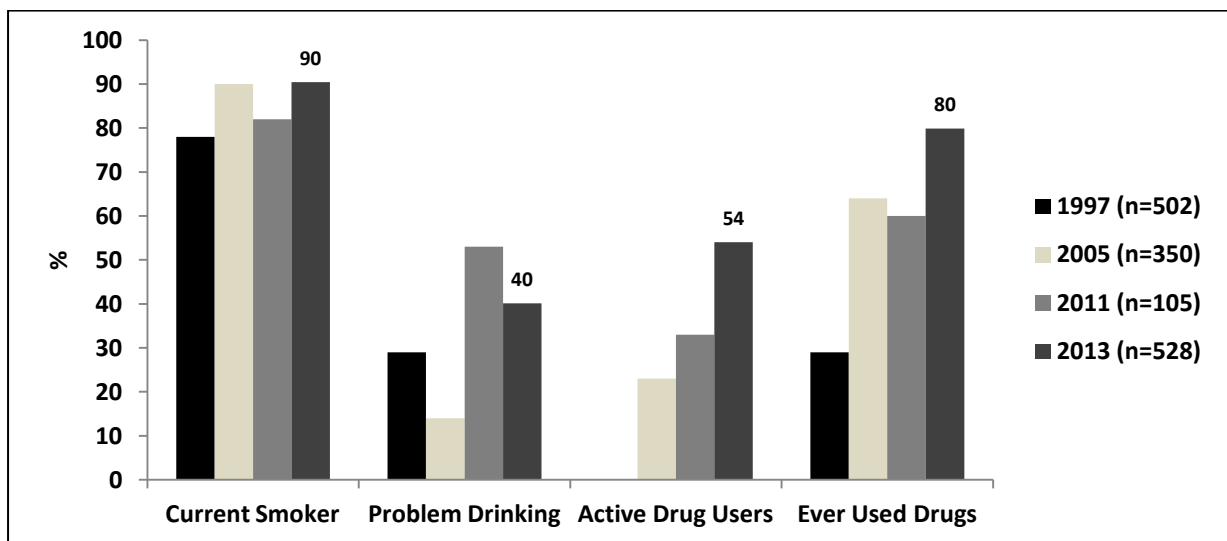
3.4 Blood borne viruses

The prevalence of blood borne viruses among the homeless population in Dublin can be estimated from the results of the 2013 survey of over 500 participants; 3.6% were HIV positive, with 4.8% and 28.5% having diagnoses of hepatitis B and C, respectively.(13)

3.5 Risky behaviours and drug use

The proportion of respondents who identified themselves as being current smokers and those who reported harmful drinking patterns increased over the time period (Figure 3.5).

Figure 3.5 Risky behaviours and drug use, 1997-2013

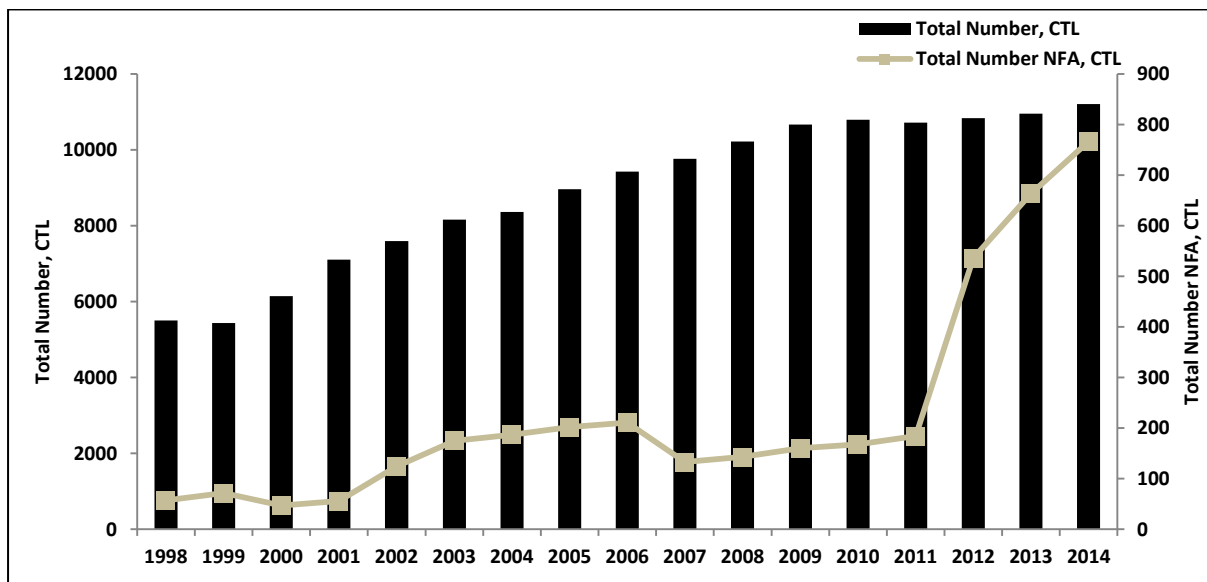


Similarly, the proportion of the study cohort who had ever used drugs increased from 29% in 1997 to almost 80% in 2013. There was also large increase in the proportion of respondents who identified themselves as active drug users, increasing from 23% of the study cohort in 2005 to 54% in 2013. Cannabis, heroin and street benzodiazepines were the three most commonly used drugs in 2011 and 2013.

3.6 Methadone Treatment

All service attendees receiving methadone are registered on the Central Methadone Treatment List (CTL). The total number of people on the List increased from 5,498 in 1998 to over 11,000 in 2014 (Figure 3.6). Between 1998 and 2014, the percentage on the CTL who were registered as being of no fixed abode increased from 1% (57/5,498) to 7% (766/11,206). It increased from 2% (184/10,711) to 7% between 2011 and 2014 alone (Figure 3.6). While trend data is not available in relation to Dublin specifically, in May 2015 a total national figure of 664 persons of no fixed abode were recorded on the CTL, of which 534 (80.4%) were in Dublin (J. Barry, TCD).

Figure 3.6 The Central Methadone Treatment List. Total numbers and numbers registered as being of no fixed abode.

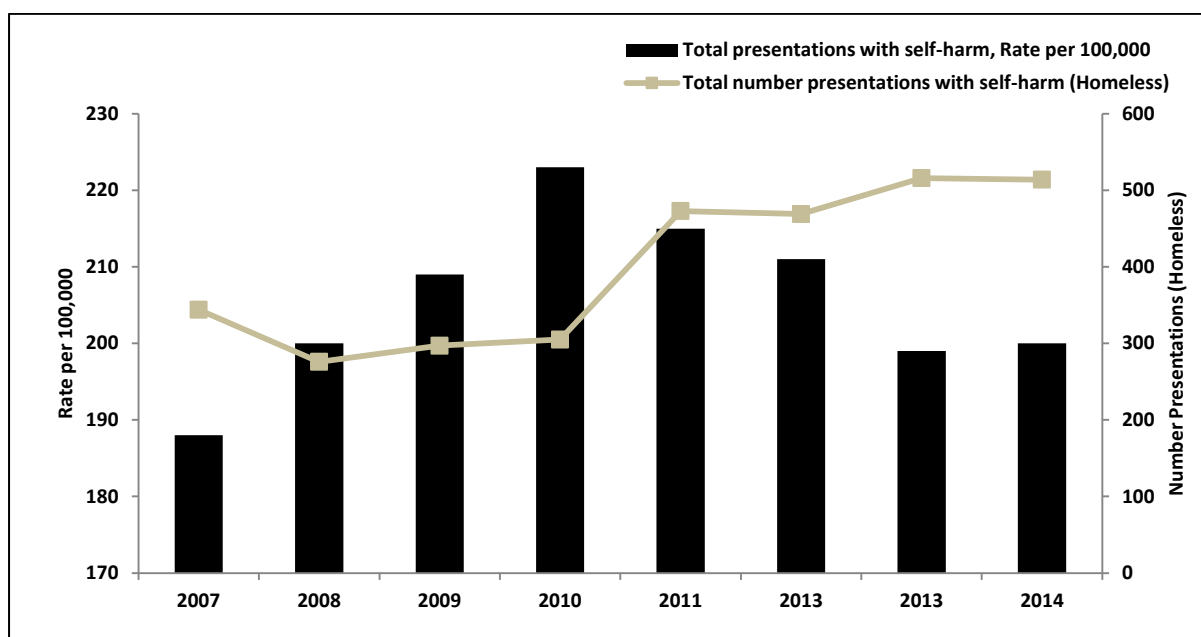


3.7 National Self-Harm Registry Ireland

Nationally, the rate of self-harm in Ireland has increased since 2007. The largest increase was observed between 2007 and 2010, where the overall rate increased from 188 to 223 per 100,000 (+19%). Despite decreases in the rate of self-harm in recent years, the rate is still 6% higher than that recorded in 2007 (+14% for men, 1% for women) (Figure 3.7).

On average, approximately 11,000 presentations are recorded by the Registry, with approximately 500 of these registered as being of no fixed abode (Figure 3.7). The proportion of presentations recorded by the Registry in people who were homeless increased from 3% in 2007 to 5% in 2014. The absolute number of presentations increased by 49% between 2007 (n=344) and 2014 (n=514) (Figure 3.7). This increase was more pronounced among women (+68%).

Figure 3.7 Total presentations with self harm, and number of presentations with self harm among homeless, 2007-2014

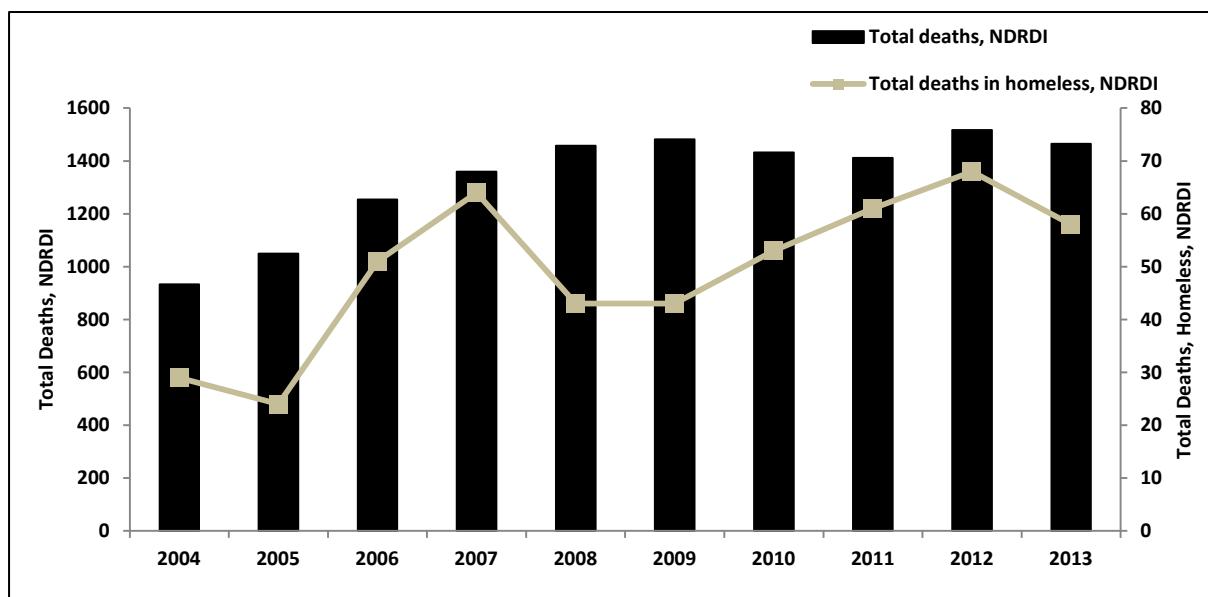


3.8 National Drug Related Deaths Index

The number of drug- and alcohol-related deaths recorded nationally increased by 57% from 2004 (n=933) to 2013 (n=1,465), inclusive. Over that time period there were 494 deaths nationally of individuals known to be homeless (Figure 3.8). Almost two thirds (65%, n=320) of these deaths were in Dublin.

The number of drug- and alcohol-related deaths among those who resided in Dublin increased by 41% from 2004 (n=419) to 2013 (n=590). The number of deaths amongst those identified as homeless and who died in Dublin fluctuated over the time period with an overall upward trend. Twenty two (54%) of the 47 deaths in Dublin in 2013, in those identified as homeless, were directly attributable to poisoning. Of these, 17 (77%) involved polydrug use. Opiates were implicated in 21 (95%) of the deaths.

Figure 3.8 Total recorded deaths and number of recorded deaths in homeless in Dublin, NDRDI, 2004-2012



4 Stakeholder perspectives

4.1 The perspective of outreach workers in Dublin

In July 2015 a meeting took place with a group of approximately 35 outreach workers who are based in the inner city and counties Dublin and Kildare. The workers were asked to provide their views and recommendations with respect to the current upsurge in cases of HIV among PWID. A number of the issues identified during this meeting are directly linked to the provision of homeless services as outlined below;

1. There is a lack of education and training for staff working in emergency accommodation, with respect to addiction in general and injecting drug use in particular.
2. There is a lack of up-to-date information and messaging for PWID regarding addiction, the risks associated with drug use, and the services available to those seeking to reduce those risks.
3. The current system of directing clients to specific HIV testing centres was felt to be cumbersome and to represent a barrier to testing for the most chaotic drug users within the population.
4. It was suggested that while services are still being provided, despite funding cut-backs, the cut-backs have meant that the quality of those services are not as they once were, with consequent impact on client-service provider interaction and relationship building.

The outreach workers made a number of recommendations regarding how things might be improved;

1. Education and training for staff working in emergency accommodation.
2. Services within emergency accommodation should be expanded, and needle exchange within hostels should be facilitated. The harm minimisation message needs to be always given with needle exchange.
3. There should be an increase in the number of walk-in facilities for HIV testing, and testing within hostels should be facilitated.
4. Outreach services need to be expanded – this needs to be street-based rather than office-based.
5. There is a need to revisit HIV messaging and consideration should be given to the development of a targeted education and awareness campaign.

4.2 The perspective of those working in hostels in Dublin

A number of meetings took place with staff working in hostels in Dublin city centre. A number of common themes were identified through these meetings;

1. Injecting drug use is a feature of hostels in Dublin and the concept of a ‘dry’ hostel with respect to drug use is a misnomer.
2. The daily allocation of emergency beds, while aimed at providing equitable distribution of beds on a first come-first served basis, exacerbates the chaotic lifestyles of those using the services and denies them the stability of knowing where they will be sleeping for even a few days at a time. It was argued that an unintended consequence of this system is that the most chaotic are the ones most unlikely to get a bed because they are not organised enough to ring the freephone service at the appropriate times. In addition, the daily allocation of beds removes the opportunity for hostel staff to develop relationships with clients or for them to identify potential issues and refer clients to appropriate health or other services.
3. Staff in hostels would welcome education and training, both in relation to drug use and harm reduction, but also in relation to specific health issues of particular concern within this population.
4. The past year has seen a change in the profile of people using homeless services in Dublin. There are now more ‘financial’ or ‘economic’ homeless; these have none of the traditional risk factors for homelessness but who, for a variety of reasons, including job loss and rent costs, have ended up in need of emergency accommodation.

4.3 Safer Injecting Rooms

In 2015 the Ana Liffey Drug Project (ALDP) published their position paper on the provision of Medically Supervised Injecting Centres (MSIC) in Dublin (14). MSICs are one type of drug consumption room (DCR). There are three models of DCR operational in Europe at present: integrated, specialised and mobile (15); the vast majority are integrated in low threshold facilities, in which they form part of a range of services within a facility. Specialised DCRs offer a narrower range of services directly related to consumption. Mobile DCRs are operational in Barcelona and Berlin.

The ALDP position paper describes MSIC as “medically supervised spaces where people can inject drugs in a clean and hygienic setting off the street. They are a widely recognised response to injecting drug use, and are employed in a number of countries, including Switzerland, Germany, Spain, the Netherlands, Australia and Canada.....An MSIC does not provide people with drugs to consume; people arrive at the MSIC with their drug. At the MSIC, they can access clean injecting equipment, and medical and social interventions, such as testing for blood borne viruses, advice on safer drug use, and referral pathways to treatment and rehabilitation” (14).

A potential barrier to the introduction of MSICs in Dublin is the fear that it will lead to 1) increased prevalence of drug taking and addiction and b) increased levels of crime in the vicinity of the MSIC. In 2015, however, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), advised that “the benefits of providing supervised drug consumption facilities may include improvements in safe, hygienic drug use, especially among regular clients, increased access to health and social services, and reduced public drug use and associated nuisance. There is no evidence to suggest that the availability of safer injecting facilities increases drug use or frequency of injecting. These services facilitate rather than delay treatment entry and do not result in higher rates of local drug-related crime”(15).

At present, it is illegal to allow people to inject drugs on premises. Thus, in order for MSICs to operate in Ireland, there would need to be legislative change; the Voluntary Assistance Scheme of the Bar Council of Ireland has developed draft legislation in relation to this matter.

5 Summary of findings

In July 2015, Dublin City Council reported that there were 21,592 outstanding applications on the social housing waiting list, the highest number ever recorded on this list. The number of individuals accessing emergency accommodation increased by 28% to 3,095 in the year to June 2015 – the highest number recorded since counting began in 2010. An average of 5.2 new people per day required placement over the period from April to June 2015.

245 adults, that were new to homeless services, presented with child dependents over the over the period from April to June 2015. There was a 43.1% increase in the number of families accessing emergency accommodation between January and June 2015.

Despite an increase in the proportion of the homeless population with medical cards and the development and roll-out of the Safetynet primary care service for the homeless, the health needs of this cohort have remained substantial over the past fifteen years. In particular, there has been an increase in documented adverse mental health, with over 50% of respondents in 2013 (32% in 1997) reporting a diagnosis of depression, and 29% reporting suicidal ideation in the previous 6 months.

While there were decreases in the proportions of respondents with diagnoses of HIV and/or Hepatitis C between 2005 and 2013, these decreases mirrored national trends for PWID. It is thus reasonable to assume that, as the situation has worsened among PWID in the interim, so too will the proportion of the homeless population with these diagnoses have started to increase as well.

Evidence across a range of parameters suggests that prevention and treatment of drug and alcohol addiction within the homeless population has not been adequately addressed over the timeframe. Almost 40% of this population now identify drug and/or alcohol problems as the primary cause of their homelessness and 80% of those who are homeless have used drugs. In addition, the proportion of homeless who are current drug users has increased dramatically over the past ten years, from 23% in 2005 to 54% in 2013.

There are approximately 766 clients on the central methadone treatment list (CTL) who are registered as being of no fixed abode (NFA). There was a step change increase in the

proportion of those on the CTL who were registered as being of NFA in 2011; between then and 2014 the proportion increased from 2% to 7%.

The proportion of presentations with self-harm recorded by the National Self-Harm Registry Ireland in people who were homeless increased from 3% in 2007 to 5% in 2014. The absolute number of presentations increased by 49% between 2007 (n=344) and 2014 (n=514)

It is perhaps surprising, given media coverage in 2015, that relatively few respondents cited financial issues as the primary reason for their homelessness; anecdotal evidence suggests that there are now a significant cohort who are homeless as a direct consequence of financial issues and it may be that this has deteriorated in the two years since the last survey was carried out in 2013.

6 Recommendations

The recommendations below are based on the information outlined thus far and are influenced by discussions with those who provide services to the homeless in Dublin.

Coordination between agencies working to address the health and social care needs of the homeless needs to be improved and the complex interaction between homelessness and health should be recognised. Two measures are proposed:

An evaluation of the homelessness sector including its structures, service delivery and coordination arrangements is to be commissioned by the Department of the Environment, Community and Local Government in 2015 (Summit on Homelessness, December 2014). This evaluation should include representation from the HSE Department of Public Health East to ensure that the structures, service delivery and coordination arrangements are assessed from a health perspective, and to ensure that recommendations are health-proofed.

The Dublin Joint Homeless Consultative Forum is a multidisciplinary forum aimed at tackling homelessness in Dublin. Its HSE membership includes representatives from Social Inclusion. However, when issues affecting the health of the homeless arise such as HIV increase/ outbreak, the local department of Public Health in the east region in Dublin has responsibility to coordinate the response. The 2015 HIV Incident team set up by the Director of Public Health to control the recent upsurge in HIV includes a number of HSE entities and related health agencies (including primary care, laboratory, addiction, infectious disease and sexual health services) and NGOs. The outbreak investigation, control measures and information dissemination has been a major factor in the reduction of new cases.

It is recommended therefore that the HSE include a nominee from the local Department of Public Health in Dublin to the Dublin Joint Homeless Consultative Forum.

The system of daily allocation of emergency beds through the Central Placement Service should be examined to see if places can be allocated on a weekly basis. This would give those

using emergency accommodation a marginally greater level of stability. It would also allow staff in those facilities the opportunity to a) cohort their clients more appropriately b) work with and develop relationships with the clients, such that issues can be identified and appropriate referrals made.

Pragmatic steps should be taken which recognise that drug use, and associated risky behaviour, are a feature of hostels in Dublin at present. These steps should include

- Engagement, education and training of staff working in these facilities regarding drug use and harm reduction.
- The implementation of harm reduction measures including sharps disposal bins and *targeted* needle exchange.

The HSE should streamline its specialist consultant-led mental health and primary care services to ensure in-reach services into all emergency accommodation settings across the Dublin Region. This measure was promised as part of the Government's Summit on Homelessness in December 2014 and was due to be implemented in Q1, 2015.

A medically supervised safe injecting room is required in Dublin city centre. Legislative change will be required in order to facilitate this. An assessment of drug overdoses and resulting deaths in Dublin is required, such that the most appropriate location for the injecting room can be identified.

A targeted information and awareness campaign, aimed at highlighting bloodborne viruses, the risks associated with injecting drug use and the importance of risk reduction practices, among PWID, should be developed in conjunction with PWID.

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