

Reaching the ‘Hard to Reach’.

Paper presented at Conference on ‘Problem Drug Use and Homelessness: Two Faces of Social Exclusion’, Dublin Castle, 18th July, 2002 by Caroline Corr.

1. Introduction

Good afternoon. The paper I will present today examines the issues and barriers faced by workers in reaching the ‘hard to reach’. Firstly I will briefly define ‘hard to reach’ populations. Then using the example of Merchants Quay Ireland’s Drugs Outreach Service, I will show how outreach is an effective strategy in reaching these groups. Finally, I will summarise some of the barriers and problems faced by those working with ‘hard to reach’ populations. I would like to thank all our workers in our low threshold services at Merchants Quay who are a constant source of information to the Research Department not only for this paper, but also for so many other projects. In particular I would like to thank our outreach workers Paul Holdaway and Bernie Byrne and also Franz Kavanagh who worked in Merchants Quay last year.

2. Who are the ‘Hard to Reach’?

Homeless people and drug users are not homogenous groups and while many of them are difficult to contact there are certain groups who are particularly ‘hard to reach’. The ‘hard to reach’ are marginalised, isolated, socially excluded and highly mobile. They are often not in contact with any services, as they are either unaware of them or do not wish to access them. The following is a list of groups who could be considered ‘hard-to-reach’, although it is certainly not exhaustive. This typological classification is useful in characterising individuals and in identifying service needs. None of the following groups are mutually exclusive and when these characteristics are multiplied in the same individual, he or she is likely to suffer increasing marginalisation (Starmans, 1998).

Younger chaotic drug users are particularly ‘hard to reach’ and the proportion of young people presenting for treatment has decreased (O’Brien *et al.*, 2000). Many view drugs workers with suspicion and do not identify with services provided, which Gemma will be talking about later.

Furthermore, many are in denial regarding the potential harm associated with their drug use and do not see the need to engage with drugs workers.

Homeless Drug Users are generally considered to be a 'hard to reach' group as they are excluded from many homeless services and are often refused access to hostels, as they do not accept people using drugs. Moreover, as Liza and Dervla pointed out in one of their reports, the task of funding drug use makes it very difficult for homeless people to commit themselves to the length of assessment procedures involved in accessing treatment programmes (Costello and Howley, 2000). In a study carried out in Merchants Quay among regular attendees at the needle exchange, 93% had experienced homelessness at some point in time and 63% reported being homeless at the time of interview (Cox and Lawless, 1999).

Female drug users, are under-represented in treatment services (Gossop, *et al.*, 1990). Those with children, are particularly reluctant to access services and tend to remain a hidden population (Goode, 2000). They are difficult to reach as they need to maintain a low profile due to illegal activities, lack of stable housing and the stigma of being a mother with a drug problem (Goode, 2000). Furthermore, drug-using mothers often avoid seeking help for their problems because of the risk of social service intervention (Goode, 2000).

Some female drug users are also involved in street work and fear attending social services because of stigmatisation (Starmans, 1998). Similarly, young male sex workers are a 'hard to reach' group as they are often suspicious of authority and therefore avoid services (Illing *et al.*, 1993).

Drug users from ethnic minorities do not access services due to lack of knowledge, language barriers and lack of experience in drug services to deal with this group (Ana Liffey, 2001). Furthermore, few agencies have employees from ethnic minorities, which further alienates these groups (Perera *et al.*, 1993).

Homeless people and drug users are prone to more health problems than the general population. Homeless people are particular prone to dental health problems, asthma, bronchitis

and emphysema (Feeney *et al.*, 2000). Drug users are also at significant risk of HIV and Hepatitis due to risky injecting practices (EMCDDA, 2001). It is estimated that between 12% and 15% of the injecting drug-using population in Ireland are HIV positive (Johnson *et al.* 1994; O’Gorman, 1998). Furthermore it is estimated that between 70% and 95% of injecting drug users in treatment have some strain of Hepatitis C (Smyth *et al.*, 1995). However, many of them show a lack of desire in addressing their health problems as they have more pressing demands such as housing, money and food (Rhodes *et al.*, 1991). Therefore concerns relating to HIV, Hepatitis C, dental care and other health problems are usually of secondary importance.

Rough sleepers are probably the most marginalized and isolated group among the homeless population and therefore ‘hard-to-reach’. They develop social networks and friendships on the street and often avoid services. According to the Homeless Agency (2001) they have ‘most difficulty of all homeless people in accessing homeless and other services, due to a combination of their own chaotic lifestyles and the way in which services are organised’ (46).

Homeless youths often do not access services as they are inadequate or even non-existent. Their behavioural and addiction problems often go unrecognised or not responded to for years (McVerry, 2001).

Women’s homelessness is also frequently hidden. Women who are homeless seek to avoid hostels and applying for local authority accommodation and make all kinds of arrangements to avoid street homelessness (Padraic Kenna, quoted in *Cornerstone*, Issue No. 7).

After *Planning for the Future* in 1984, psychiatric care shifted from an institutional setting to a community-based setting. This has led to *homeless people with mental health problems* being discharged prematurely without much support and assistance to reintegrate. Furthermore, there is evidence to suggest that homelessness is associated with deterioration in mental health (O’Cleary and Prizeman, 1998). It is estimated that between 30% and 40% of homeless people in Ireland have mental health problems. A recent edition of *Cornerstone* (No. 11), the Homeless Agency’s magazine, was devoted to the issue of mental health and homelessness.

It stated that homeless people with mental health problems were neglected, because their mental health problems,

have not been addressed as comprehensively as they should have been; stigmatised through pervasive attitudes to mental ill-health; and invisible, because too many homeless people with a mental health problem have fallen through the net and lost contact with health services (6).

Homeless people with alcohol-related problems are another ‘hard-to-reach’ group, who are alienated from many homeless services, such as day centres and hostels, as most of them operate a ‘no drink’ policy. It is estimated that around 50% of homeless people in Dublin are alcohol dependent (Feeney *et al.*, 2000). Liza and Dervla concluded in one of their reports that homeless street drinkers are the most marginalised and socially excluded among this group as they have multiple and varying needs that are not being met by existing services (Costello and Howley 1999).

According to British research, *homeless people with dual diagnosis* (i.e. alcohol and mental health problems) are often disowned by both treatment services and psychiatric units. This is because these services are often fragmented which makes it difficult for clients to get treatment from both (O’Leary, 1997).

3. Merchants Quay Ireland’s Drugs Outreach Service

‘Hard-to-reach’ groups require imaginative and innovative responses. While the new National Drug Strategy set clear targets for the next 7 years in developing new drug treatment places, it failed to clearly state how ‘hard-to-reach’ drug users could be linked into services through the provision of more low threshold services and crisis counselling. Merchants Quay felt that one approach which would help those who are ‘hard to reach’ was more targeted outreach programmes and therefore set up one in December, 2000. This is a *drugs* outreach service funded jointly by the Health Board and Dublin City Council. There are other outreach services in Dublin specifically targeting homeless people run by Simon and Focus and others run by the Health Board and different organisations.

The overall aims and objectives of Merchants Quay's Drugs Outreach Service are:

- to identify and contact individuals and groups of chaotic drug users;
- to provide information and advice on safer drug use;
- to encourage and sustain changes towards safer drug use;
- to seek to draw those not in contact with services into centre – based services;
- to discuss health issues; and
- to refer clients to relevant agencies.

As well as reducing harm to drug users, the Outreach Service also aims to reduce harm in the local community by:

- collecting and disposing of used needles; (and incidentally is the only outreach service in Ireland that does so)
- liaising with other outreach programmes working with homeless people and providing them with advice and support on dealing with drugs issues;
- establishing links with other community groups, the local Policing Forum, Dublin City Council and local business interests;
- promoting good community relations in order to relieve some of the local tensions; and
- encouraging drug users to have greater sensitivity to the concerns of the local community.

The model we use is mainly based on the provider-client model (Rhodes, 1996). The outreach service uses a combination of professionally trained and other workers to help change clients' behaviour in the community. It is mainly based on one-to-one interactions. Nevertheless, the Merchants Quay model also has some of the characteristics of a Community Outreach model. The team work with networks of drug users as 'changing group norms and practices is an effective method for facilitating individual as well as collective behaviour change' (Rhodes, 1996). Community Development is also an integral part of the outreach work, as the outreach workers liaise with local community groups and local businesses in reducing levels of public nuisance.

At the end of the first year of the Outreach Service, the Research Department at Merchants Quay carried out an evaluation of it and I'm going to summarise some of the main findings which demonstrate how outreach is a successful strategy for reaching the 'hard-to-reach'.

During this year, the outreach workers met 262 clients. Almost 3,000 needles were collected and disposed of by the outreach workers. Among the clients 69% were male and 31% were female. Over half those met were under 25 years of age. Practically all the clients were Irish. However the outreach team also met 4 English people, 1 Scottish and 1 African person. Over a quarter of those contacted were new clients which indicates that the outreach team was successful in contacting 'hard to reach' groups of drug users.

Overall three-quarters of those contacted (75%) were homeless at some point during the year. This is particularly concerning given the fact that research studies have found that drug use increases when people are homeless (Cox and Lawless, 1999; Fountain, 2001). Heroin was used by 79% of the clients. Almost one in three of the clients were polydrug users. The vast majority of clients used local streets for drug taking or street drinking. Other popular sites were churches, parks and home. Almost a third of the clients were not in contact with any services.

During the year the outreach workers:

- gave out information and advice on safer drug use to over one hundred clients
- carried out Motivational Intervention with one in three of the clients (which is a therapeutic tool to help individuals recognise and do something about their present or potential problem)
- provided information on health issues with a quarter of the clients
- and made referrals to treatment services for 45 clients (which are important for facilitating indirect change)

Other services provided by the outreach team included:

- building rapport with the vast majority of clients
- and providing information on accommodation

4. Barriers to Helping the 'Hard-to-Reach'

The evaluation of the first year showed that the outreach workers were successful in contacting 'hard-to-reach' drug users, including those not in contact with services, homeless drug users, young drug users and non-nationals. Despite this, Merchants Quay's drugs outreach team, and others, work under serious constraints. I am going to highlight a few of the main obstacles which our drugs outreach workers face but these are also applicable to those working with homeless people, street workers and other 'hard to reach' populations.

The Homeless Agency (2001) acknowledged in *Shaping for the Future* that street outreach by itself 'cannot be effective if there is no accommodation or other services to refer people on to' (52). The lack of available and suitable emergency, transitional and long-term accommodation for 'hard to reach' groups makes it practically impossible for outreach workers to refer clients into accommodation. While accessing accommodation can be problematic for all homeless people, it is particularly difficult for certain groups such as homeless people with alcohol problems and/or mental health problems and drug users. There is a serious lack of appropriate accommodation for homeless people with mental health problems (Brooke, 2002). People with alcohol or drug related problems cannot access accommodation as many hostels operate on a 'no drink' or 'no drugs' policy. Recently Clancy Barracks has successfully accommodated these groups in their emergency accommodation. However, there is still no 'wet' hostel or a hostel for drug users in Dublin. This issue is particularly pertinent for homeless drug users as the Housing (Miscellaneous Provisions) Act, in 1997 incorporated exclusion orders for persons believed to be engaging in anti-social behaviour. It also provided for the speeding up of procedures to evict known drug dealers from local authority estates. The result has been that drug users are leaving local authority housing and finding themselves in a cycle of homelessness (Memery and Kerrins, 2000).

As well as problems with referrals to emergency accommodation it is practically impossible for outreach workers to provide and facilitate referrals onto a range of services or programmes. For instance, outreach workers face great difficulty in referring clients to psychiatric services because, as Simon Brooke (2002) recently pointed out, there is a severe shortage of mental health facilities for the homeless mentally ill and there is also the catchment area problem.

Drugs outreach workers have great difficulties in referring clients onto methadone prescribing services and residential programmes due to lack of places, long waiting lists, perceived discrimination due to not having an address and programmes based on actual catchment areas (Costello and Howley, 2000). This is illustrated by the following quote from an outreach worker:

The reality is that someone will come to you and they'll say I want to get off this shit, I want to get on phy, I want to sort my life out. You ring around a few clinics, you find that the nearest waiting list is 6 or 7 months. So you tell the client, well if you can just keep your drug use under control for 7 months, we might be able to get you on a phy course. You're telling them to their back as they're walking away from you. It's pointless.

(Outreach worker, quoted in Corr, 2002, *in print*)

Our evaluation of Merchants Quay's Outreach Service, found that 59% of clients were not in contact with any drug treatment service. By the end of this year, there will be a minimum of 6,500 places in drug treatment which leaves at least 7,000 drug users outside treatment. Similar problems are faced by workers referring homeless people to alcohol treatment services as these are not necessarily appropriate to the needs of the homeless and in any case are very difficult for them to access (Costello and Howley, 1999).

As well as the difficulties referring clients onto existing programmes, there is a lack of treatment options for chaotic drug users or homeless people with alcohol problems. For instance methadone maintenance, methadone detox and total abstinence are still the only treatment options for chaotic drug users in Ireland and the new National Drugs Strategy made no commitment to offering alternative treatment options such as prescribing buprenorphine or diamorphine, or as Mary will be talking about shortly, safe injecting rooms. Neither was any acknowledgement given to the potential of alternative approaches such as acupuncture. Similarly alcohol treatment programmes are unsuitable for homeless people with alcohol related problems, as they are mainly based on the Minnesota Model and involve a great deal of group therapy. I would agree with Shane Butler's (1995) view, that this is unreasonable and highly unrealistic when applied to street drinkers. However, it is important to welcome the Homeless Agency's proposal for developing harm reduction options such as drop-in centres where alcohol can be consumed.

Trying to refer clients to health services is also problematic for outreach workers as services are often unavailable, unsympathetic, inappropriate or ill equipped to meet clients' needs (Harvey, 1998; Feeney *et al.*, 2000). Our evaluation of Merchants Quay's Outreach Service found that only 10% of clients were in contact with health services. Outreach workers find it difficult to encourage clients to attend health services due to clients' perception that health care staff are unhelpful and insensitive, the financial difficulties and also problems applying for a medical card (Holohan, 1998; Feeney *et al.*, 2000; Lawless, 2002). As one outreach worker explained:

If they have bad wounds or anything you tell them to go to the hospital. They come back with horrendous stories of waiting there for 12 hours and then get treated like shite because they are a drug user. So they won't go, they just won't go anywhere near the health service.

(Outreach Worker, quoted in Corr, 2002, *in print*)

Because of the many gaps in service provision, outreach workers need to be supported in bringing services onto the streets. However this is problematic. For instance, according to Merchants Quay's outreach workers one of the most pressing needs of street injectors is access to clean injecting equipment. However, outreach workers from Merchants Quay do not carry out needle exchanges on the street. If they did, this could prevent situational sharing as the following quote illustrates:

There has been times where I have seen needles swapping around and I'd love to have a pack so I can say, you don't need that, use this.

(Outreach worker, quoted in Corr, 2002, *in print*)

While drug users' views are represented by UISCE and similar groups; and homeless people's opinions will be heard through the new voice programme, there is still limited use of peer-based approaches to service provision in Ireland. However, outreach workers feel that if this approach was more widespread, more 'hard-to-reach' groups would be met:

For the actual work that we do you need someone who knows the lifestyle, knows what's going on [...] I think having an understanding of the streets and knowing that helps you with the clients. I think you can make contacts a lot easier [...] I think if there was an ex-user in every major area around, I think information would get around a hell of a lot quicker.

(Outreach worker, quoted in Corr, 2002, *in print*)

It is likely that a peer-based approach would work well in the Irish context as many drug users and homeless people are in contact with each other.

A multi-agency approach to reaching the 'hard-to-reach' is crucial. Outreach services and day centres which establish effective links with other voluntary and community organisations and with local statutory services meet the needs of their service users more effectively. However, staff working in voluntary organisations have reported that they have encountered difficulties with other agencies when trying to advocate on behalf of the clients, as one full time project worker explained:

I find to be honest with you that other agencies don't like to help you which is stupid as we're all in the same thing. [...] You'll find that other agencies are not properly funded the way we are, don't like to share and don't like you to come down and visit. No this is the way that we do this, we're happy with the way it's working for us and you get a blank wall. [...] And you feel like shaking them you know because we're all working for the same thing, so why?

(Full-time project worker, quoted in Corr, 2002)

As well as often facing barriers with other agencies, outreach workers also face resentment from local residents who often see homeless people and drug users as a threat to the safety of the local community. However feedback on Merchants Quay's Outreach Service showed that it was contributing to a more secure urban environment. As one local business person commented:

The Outreach Service has given us a channel of communication and help, other than the Gardai. It has also reduced the problem somewhat.

(Local business person, quoted in Corr, *in print*)

This person went on to comment that:

The work of the Outreach Service is good but more staff and resources are required to increase its impact.

(Local business person, quoted in Corr, *in print*)

The very nature of outreach work means that it is time consuming. It is totally unrealistic to expect outreach workers to succeed in reaching hidden populations without the necessary staffing and resources. When these measures are in place, outreach workers should extend their services to the evenings and weekends, when it is most needed:

The evenings and weekends is when it's needed [...] when everywhere else is shut. I know at night time's needles and syringes are being sold round here, you know. We've heard that they're getting sold for 15 quid just for a barrel and a spike.

(Outreach worker, quoted in Corr, 2002, *in print*)

More staff would also mean that outreach workers could operate beyond the designated boundaries to target people, not areas. Chaotic drug users and homeless people are highly mobile and do not frequent the same places in Dublin, in part as a result of police pressure. For instance, the majority of clients met by Merchants Quay's outreach service were met only once. Therefore, extending the boundaries and times would help them reach more hidden groups.

Conclusion

This paper has shown that outreach is an effective strategy in reaching 'hard to reach' populations. While outreach is important and valuable, it is equally important that centre-based services are designed that can accommodate the 'hard-to reach'. There is a need therefore for the relevant government agencies to commit themselves to establishing other imaginative and innovative responses. Those mentioned in this paper include the setting up of a wet hostel and a hostel for drug users, alternative treatment options such as safe injecting rooms, alternative replacement therapies and increasing the number of places already available on current programmes. Thank you.

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