HEALTH STRATEGY 2001

Submission by the Simon Community of Ireland to the Department of Health on its review of the Health Service

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Role and brief of the Simon Community of Ireland

The Simon Community is a caring and campaigning movement that has been working alongside homeless people in Ireland since 1969. There are four Simon Communities in the Republic: in Cork, Dublin, Dundalk and Galway. Each Simon Community is independent and autonomous. Together they form a federation called the Simon Community of Ireland. Services provided by the Simon Community include supported housing projects, outreach, emergency shelters, work/training projects and resettlement assistance.

Scope of submission

This submission is in two sections.

Section one outlines **the present situation** for people homeless and inadequately housed. This section focuses on three key areas:

1.1 Health needs of people who use homeless services
1.2 Health problems faced by those inadequately housed
1.3 Deficiencies in the operation of the present system.

Section two makes 15 **recommendations** to achieve a more client-focused system for people who are homeless. This section makes recommendations in three key areas:

2.1 Care for those mentally ill and homeless
2.2 Treatment of other health problems experienced by those homeless
2.3 Co-ordination of health and housing policies

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Section 1 – The Present Situation

The health of people in Ireland is generally better than it has ever been before. However an overall improving picture masks marked inequalities between different groups of people. In this section we set out the extent and nature of the health needs of people homeless.

1.1 Health needs of people who use homeless services

General Health
Today, homeless persons make up a growing vulnerable population that has an unacceptable high risk for preventable disease, progressive morbidity and premature death. Homeless people experience much higher levels of Hepatitis-C, HIV, TB, poor nutrition, drug and alcohol addiction and mental health difficulties than the general population.

The Eastern Health Board[1] has tabulated the incidence of general health problems among those homeless. It found that the homeless have a much higher prevalence of chronic physical disease and a lower life expectancy than those of comparable age in the general population.

According to the report, the prevalence of homeless persons experiencing chronic physical and mental illnesses is as follows:

Condition	Prevalence %
Chronic Physical Illness	
Diabetes	2.5%
Hypertension	12.7%
Arthritis	13.7%
Heart Disease	5.1%
Epilepsy	5.3%
Tuberculosis	2.7%
Respiratory Disease	15.8%
Peptic Ulcer	13.7%
Chronic Psychiatric Problems	
Depression	32.5%
Anxiety Disorder	27.6%
Other Problems	
Dental Problems	37.1%
Skin Problems	16.0%
Foot Problems	21.3%

[1] Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin, Holohan, 1997

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A report of the health status of people homeless in Cork[2] has also found extreme manifestations of ill health among the homeless population there. Of those staying in the Cork Simon shelter, only 22% had a health status that would be considered normal by the general population.

The report found that of the hostel dwellers:

- 40% had a serious psychiatric illness (including depression)
- 6% had respiratory problems
- 5% had mobility problems
- 42% had problems of alcohol dependency
- 18% had other physical problems.

Mortality Rates of Rough Sleepers

According to research from Crisis in the UK[3], the average age of death of a homeless person sleeping rough is 42 years. From our experience of working with street homeless in Cork, Dublin, Dundalk and Galway the mortality rates of rough sleepers in Ireland are along similar lines. In Dublin, for example we are aware of 7 incidences of rough sleepers under the age of 25 who died prematurely in the last year.

Dental Health

Problem of poor dental health is also exceptional among the homeless population. A report by the Dental Clinic Cornmarket[4] finds that 20% of hostel dwelling men in Ireland have lesions of their Oral Mucosa. Hostel dwelling men also have large unmet dental treatment needs, including:

- Extractions
- Filings
- Gum Disease
- Treatment for Trauma

Registration with a GP and Use of Hospital Services

There has never been a structured, managed health care response to the needs of persons homeless. Despite the extreme poor health experienced by people homeless, a significant proportion of homeless people are neither registered with a GP or hold a medical card. Dublin Simon's Outreach team, which made 1,426 contacts in 2000, found that 50% of the rough sleepers met did not have a medical card or a GP. Their sole source of medical support was A&E Departments of general hospitals.

[2] Cork Simon, Homeless in Cork, 1998
[3] Crisis Annual Report 1999-2000
[4] Colleen O'Neill, "Oral Health of Hostel-Dwelling Men", 10th March 2000

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The use of A&E departments by people homeless because they have no other alternative is relatively expensive for the health service, ties up scarce resources in the hospital and is inappropriate to the person homeless. Because there is a complete lack of specialised care teams for people homeless, they will continue to attempt to receive treatment at A&E hospital departments, where their treatment will be dependent on the goodwill of sympathetic individuals working there.

1.2 Health problems experienced by those inadequately housed

According to Donald Acheson[5], author of the UK Government's "Acheson's Report", a 1997 research report examining the factors that affect people's health, the key components of adequate housing are:

- shelter
- adequate warmth and protection from damp
- sanitary facilities, including access to clean drinking water
- hygienic facilities for storing, preparing and cooking food
- personal space and access to privacy when required
- safe play space away from the risk of traffic
- housing which is safe from the risks of fires and other accidents.

People who are homeless can automatically be classified as inadequately housed under this definition. However there are many thousands more in Ireland who lack essential qualities in their housing to the extent that it impacts negatively on their health.

A number of studies of how health and housing interact were conducted in Northern Ireland during the 1980s. A study in Belfast[6] looked at two areas of the city, Divis Flats and Twinbrook Estate. Although both areas could be described as deprived, it was commonly accepted that Twinbrook Estate was by far the better of the two. The health study findings confirm a link between poorer housing and poorer health.

An earlier study[7] of the interaction between poor housing and health disadvantage was undertaken in Moyard Estate, West Belfast. The health effects of poor housing were most pronounced for children, with the health of 46% of children living in maisonettes reported as "not good". The

[5] Acheson D, Journal of Royal Society of Health, December 1991, "Health and Housing"
[6] Blackman T, Evason E, Melaugh M, Woods R, Housing and Health: A Case Study of two Areas in West Belfast. Journal of Soc Pol, 18.1.1-26:F7
[7] WHO, Proposals to Reduce Lead in Water Levels, October 1992

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proportion of low birth weights in the Moyard Estate was more than double that of Greater West Belfast.

Good housing has a key role to play in preventing poor health and in helping people whose health is compromised to maintain a decent quality of life. This means that their needs to be a shift towards more preventative measures that seek to tackle the root causes of health inequality.

In particular we have concerns over the health of people living in:

- *Bed and breakfasts, hostels and other forms of temporary accommodation*

Overcrowded conditions encourage the spread of infectious diseases- particularly respiratory diseases- and are most prevalent in bed and breakfast establishments, hostels, and all other forms of temporary housing.

Homeless families in temporary B+B are also likely to experience other health problems associated with cramped conditions. Research from the UK[8] finds that children staying with their families in B+Bs show behavioural disturbances such as depression, disturbed sleep, bedwetting, toilet training problems and violent mood swings.

- *Houses of multiple occupation.*

Some of the worst housing in Ireland is found in houses of multiple occupation. These include properties that have been divided into flats and bedsits. They are generally let to single people on low incomes.

The UK Government has produced research[9] that shows that an adult living in a bedsit house of three or more storeys is almost 17 times more likely to be killed in a fire than an adult living in a single occupancy house. In response the UK 1996 Housing Act places a duty on local councils to ensure that certain houses of multiple occupation with 3 or more storeys have adequate fire precautions and means of escape and the Government there has committed itself to introducing a national licensing system for these properties.

- *Unregistered private rented accommodation*

Private rented sector landlords are required to register their properties with the relevant local authority. However according to research by Threshold[10] about 80% of private rented accommodation in Ireland is unregistered. The lack of enforcement of registration regulations by local authorities in the private rented sector in Ireland is remarkable.

[8] Shelter, 1999, Homelessness and Health, Factsheet, UK
[9] Housing Executive, Northern Ireland, "Houses in Multiple Occupation", June 2000
[10] Investors in the Private Rented Residential Sector, a profile of landlords in Dublin City (Clodagh Memery and Liz Kerrins), Threshold, March 2000.

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In addition environmental health officers are required to inspect private rented sector properties. Again the standards set and the level of inspections are exceptionally low.

1.3 Deficiencies in the operation of the present system

Discharging people from hospital to emergency shelters
The practice of directly discharging people who are without permanent accommodation from hospitals, including psychiatric hospitals, to emergency shelters for homeless people has been documented by the Simon Community[11] as long ago as 1992. Today this modus operandi is more common and is causing greater problems than ever before. In Cork in 1998, 3% of the total number of people who stayed there came directly from hospital to the emergency shelter. In Dublin Simon's shelter last year a total of 47 people or 7% of all people accommodated came directly from hospital.

Emergency shelters are not suitable for people who are mentally ill. Emergency shelters do not provide "therapeutic communities" and with their large transitory populations, they are simply unsuitable for people with psychiatric problems. Yet such hostels run by voluntary organisations appear to be a major accommodation referral option for the psychiatric services.

The problem has also been referred to in a report by the Irish Division of the Royal College of Psychiatrists. They state that,
"A major source of discontent in the Eastern region is the problem posed by homeless individuals who repeatedly cross or are pushed across catchment area boundaries to St. Brendan's Hospital, or to direct-access hostels and night shelters in this hospital's catchment area, leaving the services there over-stretched and under-resourced"[12].

Case Study
"When an address is all" –Mentally ill and homeless in Dublin
Dublin Simon's Transition Accommodation "CUAS" and Dublin Simon's Emergency Shelter share the same site on Usher's Island, close to Heuston Railway Station. Many of those who stay in CUAS have stayed previously in the Shelter. A proportion of both sets of residents experience mental health problems. Yet while residents of CUAS can access treatment in St. Patrick's Hospital, (which neighbours the two houses) those staying in the Shelter must go to St. Brendan's Acute Hospital to receive treatment. The different treatment for essentially an identical client group in the exact same

[11] "Still Waiting for the Future", Simon Community's response to the Government's Green Paper on Mental Health, 1992
[12] 1998, Appendix XIII

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location is problematic, inappropriate and unjustifiable.

The Eastern Health Board's explanation for this approach is that they are constrained by guidelines which classify emergency shelter residents as homeless and transition accommodation residents as a more stable group entitled to similar care offered to people with a permanent address.

Another example of unequal treatment between settled and "homeless" people is the treatment received by residents of Dublin Simon's Supported Housing in Sean Mac Dermott Street. The 20 residents living there in permanent accommodation have been classified by the local Consultant as homeless and thus ineligible for mental health care by local service providers. The residents must access services in either St. Brendan's Hospital (where services are under severe pressure and largely inappropriate for this resident group) or in the place where are originally from even though many of the residents have been living in the house and the community since the house was established there 6 years ago and even though the house is the permanent home for all residents.

Through our work we have witnessed numerous incidences where individuals have faced grave problems because of the Health Boards' insistence that a person's access to psychiatric services is based on where the person originally came from rather than where they are now living. One example presently occurring- cited here to illustrate the problem- is of a 75 year old man staying in our Emergency Shelter in Dublin, who became homeless when he could no longer sustain his accommodation. Originally from Limerick he gravitated to Dublin where most hostels are concentrated. To receive mental health care he must travel every week over and back to Limerick by bus, requiring a considerable journey and a not inconsiderable expense because the Eastern Health Board will not treat him in Dublin. In some ways this resident is one of the luckier ones staying in the shelter in that he is receiving some form of treatment.

Failure to treat people in suitable locations because of bureaucratic guidelines

There is a difficulty in accessing appropriate and proximate mental health care for people homeless, as highlighted in the case study above. The problem is due to the "sectorisation" of psychiatric services into catchment areas which was first introduced in 1984 as a result of the report, Psychiatric Services: Planning for the Future.

The approach is still seen as an appropriate model of service delivery for the settled population. It is wholly inappropriate to the needs of homeless people because it forces homeless people to travel long distances to receive care and leaves many homeless people without a service due to the unwillingness or inability of service providers to resolve their catchment

area differences. The practical consequence of this is that most of those who are mentally ill and living in emergency accommodation in the centre of Dublin and in other major conurbations cannot get a psychiatric service because they do not come from there originally.

The application of the "sectorisation" of psychiatric services to homeless people has had two other negative impacts.

- There is little or no follow-up of patients after discharge from in-patient care. In "Planning for the Future", the 1984 report by the Department of Health's on the future of the psychiatric service, there is a commitment to "continuity of professional responsibility running through the different treatment services provided by the psychiatric team." The reality as experienced by the Simon Community is that there is no follow-up. If the person fails to turn up at the clinic, no follow-up action is taken.
- Sectorisation has led to staff generally not trained to meet and understand the needs and special requirements of some people homeless.

Failure to provide sufficient accommodation for those mentally ill and homeless

The Disability Federation of Ireland has estimated that there are 1,500 people mentally ill and homeless in Ireland[13], based on the total number of people homeless (official figures in March 1999 found 5,500 adults homeless in Ireland) and the average incidence of mental illness among the population (estimated as between 25-30%).

In the European context Ireland is exceptional in the undeveloped nature of its services to mentally ill people who are homeless. In particular supported housing is a neglected and under provided area in Ireland, with less than 200 units of supported accommodation provided for mentally ill and homeless people, the great majority of these through the voluntary sector. Health boards do provide some supported accommodation for people who are mentally ill in the community but this is mostly for compliant groups. Those who are homeless, who are generally seen and treated across the system as a non-compliant group, are not provided for.

Health Boards in Ireland do not seem to see it as part of their remit to provide accommodation to people mentally ill and homeless. As Kieron McKeown[14] states,

[13] Kieran McKeown, Mentally Ill and Homeless in Ireland: Facing the Reality, Finding the Solutions, April 1999.
[14] Ibid

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"It is surely taking de-institutionalisation to an unacceptable extreme to imply that people who are mentally ill can be cared for even if they have not been properly housed first".

Inappropriate use of acute psychiatric beds

The 1999 Eastern Regional Health Authority report "We have no beds…"[15] found severe shortages in acute in-patient beds, community accommodation, day hospital places and community-based services.

The ERHA team also found that not only was there a shortage of acute psychiatric beds, but that the chronic under-resourcing of community mental health services has led to people being admitted inappropriately to hospital beds because there are no appropriate services situated in the community. The report found that nationally homeless persons make up one third of all persons inappropriately placed in acute beds. St. Brendan's Hospital, for example, has 16 beds to serve the entire Eastern region. It is completely blocked by long-stay patients.

In our view, the use of acute psychiatric beds for persons homeless and mentally ill because there is no other safe place to accommodate them is a national scandal.

[15] An enquiry into the availability and use of acute psychiatric beds in the Eastern Health Board Region, 1999

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SECTION 2- RECOMMENDATIONS

We make 15 recommendations under the following three headings

2.1 Care for those mentally ill and homeless

In many respects the way forward on the care of those mentally ill has already been well documented. "The Psychiatric Services: Planning for the Future" written in 1984 is a strong position paper, which despite some weaknesses, sets out a forward-looking template for action. The praiseworthy nature of the paper would suggest that it is not the shortage of forward-looking policy documents that is at fault for the unacceptable treatment of people who are mentally ill and homeless. Rather it is the failure to act on these recommendations, the lack of priority given to those mentally ill and homeless and the failure to drive through implementation.

Any new health strategy for people who are mentally ill and homeless needs to acknowledge that the present system does not work and is fundamentally at odds with the objectives of equity, quality of service and accountability which are at the core of health care policy in Ireland. It must set out concrete objectives in the short, medium and long term that will address the gaping holes in Ireland's psychiatric services for people mentally ill and homeless and devise mechanisms to ensure that the objectives are met.

Under this heading we make a number of recommendations:

Recommendation 1
On grounds of principle and practice we believe that people who are mentally ill and homeless should, for the purpose of service provision, have their mental illness treated as their primary condition and their homelessness treated as their secondary condition.

On grounds of principle because persons with mental illness have a disability which creates impairment in all aspects of their lives. It is the disability and society's response to the disability that is the primary influence on their lives.

On grounds of practice because designating a person as homeless who also happens to be mentally ill creates virtually no statutory service response for that person. Local authorities in particular have no competence in dealing with the complex needs of the mentally ill. Their anti-social behaviour requirements has led to a reluctance to house potentially "problem" households in existing or new housing schemes.

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Recommendation 2
Services to people mentally ill and homeless to be free from catchment area constraints. In-patient needs of people mentally ill and homeless to be provided by a centralised service.

The Eastern Health Board[16] has acknowledged the weaknesses of the present catchment area system. We support the recommendation of the group (page 9) that,
"The in-patient treatment needs of the homeless mentally ill should ideally be provided by a centralised service, rather than devolved to catchment area services, to ensure that there is no fragmentation of service delivery". We deplore the fact that this critical recommendation has not been acted upon 5 years after the recommendation has been made.

Recommendation 3
An assessment of need of each homeless service user in the country so that the needs of each person mentally ill and homeless is fully assessed and their needs are addressed.

The Homeless Action Plan for Dublin[17] makes commitments on this question for Dublin. We call for an assessment of the need of each mentally ill and homeless person to be undertaken on a national basis by the health boards across the country.

Recommendation 4
By 2006 500 additional accommodation places with support to be provided nationally, so that persons mental ill and homeless are not staying in unsuitable accommodation, either in acute care or in unsupported accommodation, which does not match their needs.

The Simon Community's own experience in Cork, Dublin, Dundalk and Galway of working with long-term homeless people shows that, given decent housing and the appropriate level of support and care, vulnerable people with many health problems can live a full, satisfying life with a measure of independence and autonomy. Quality supported housing situated in the community performs an important health function for vulnerable people. To be effective, many levels and types of supported accommodation need to be provided, to reflect the heterogeneity of people mentally ill and homeless and to provide for the needs of different groups of individuals needing different levels of support.

Recommendation 5

[16] Report of the Committee on Services for Homeless People with Mental Health Problems, September 1996
[17] "Shaping the future, action plan on homelessness in Dublin 2001-2003", Homeless Agency, Dublin, May 2001

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Full implementation of the Guidelines on Good Practices and Quality Assurance in Mental Health Services.

In order to address the problem of lack of follow-up for people mentally ill and homeless, we call for the fuller implementation of the Guidelines on Good Practices and Quality Assurance in Mental Health Services which specify that "A mechanism should be in place to review patients who have been lost to follow up and everything possible done to find out what has happened to the patient and to take appropriate action".

Recommendation 6
Mental health services provided as a right.

We call for the principle of reciprocity to be incorporated into any future legislation on mental health. In our view the state's right to detain a person for psychiatric treatment- a right unique to mentally ill persons- should be counterbalanced by the state's obligation to provide appropriate treatment to all persons deemed mentally ill.

2.2 Treatment of other health problems experienced by those homeless

Because the medical problems of homeless people are so serious and the problems of delivery are so acute, medical services need to be tailor-made, designed and adapted to the needs of homeless people if they are to be effective. To achieve this, there needs to be a new dedication within the mainstream health service to ensure that homeless people actually receive the same level of care as the rest of the population.

The lack of health services to tend to the physical and psychological needs of homeless people has recently been reported on as part of the Government's Cross-departmental review, "Homelessness, An Integrated Strategy" in May 2000. While the Simon Community has serious concerns over the lack of recommendations on psychiatric services and the lack of acknowledgement of how quality supported housing situated in the community performs an important health function for vulnerable people, we endorse the recommendations of the group as far as they go. Under this heading we make the following recommendations:

Recommendation 7
The fast introduction of multidisciplinary primary care teams focused on working with persons homeless.

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If homeless people are to receive a service approximating to equality of care then the psychiatric and other health services need to provide their services on an outreach basis. As Dr. Tony Holohan[18] states,
"Outreach services should be put in place to engage those homeless people, especially street dwellers, whose access to medical services is limited and link then to available services. These outreach services could be linked to the other health services for the homeless. Planning of services which are sensitive to cultural differences and language difficulties will allow the social and medical services to be tailored appropriately, resulting in more effective interventions."

The proposed introduction of primary care teams with a remit concerning homelessness in Dublin inner city (as outlined in the Eastern Health Board report entitled Homelessness in the Eastern Health Board: Recommendations of a Multidisciplinary Group (March 1999)) is welcome. The recommendations were adopted in the Action Plan on Homelessness in Dublin[19] to be implemented by March 2001. Disappointingly this target has already been missed.

The Action Plan commits the Eastern Regional Health Authority to develop two multi-disciplinary teams in Dublin. There is also a need for such a team in Cork. The care teams should consist of: nurses, doctors, social workers, community welfare officers, care attendants, community psychiatric nurses, outreach drug workers and administrators, working exclusively with persons homeless. The work practices of the care teams must be based on the principles of outreach, acceptance and integrated care. These new working arrangements should include street work, visits to hostels and to other accommodation provided to persons homeless.

Health Boards in other areas with homeless populations may not find it possible immediately to develop similar teams (this does not imply that in the future they should not to develop these teams on a regional rather than a city wide basis). As an immediate response however, we propose that in areas outside of Cork and Dublin, each Health Board should identify a number of nurses, doctors, social workers, community welfare officers, care attendants and community psychiatric nurses, who are trained and directed to work with persons homeless and are charged with ensuring that homeless people actually receive the same level of care as the rest of the population.

Recommendation 8

[18] Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin, Holohan, 1997
[19] Ibid

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The provision of sufficient residential treatment places for drug addicts and alcoholics, which reflect the diversity of this client group and the diversity of their needs.

Not only are there insufficient detox residential places, but in addition many of the places are allocated restrictively. In Cork and in Dundalk, for example, a person wishing to access a detox treatment place must abstain from alcohol for at least seven days, leading in some cases to lower take up rates. In our view, a new emphasis should be placed on easy access to residential detoxification facilities for those who opt for alcohol detoxification.

Recommendation 9
Additional specific resources to be dedicated to improve the health of people homeless.

Specifically we call for:

- Ten more community psychiatric nurses to be made available to homeless service providers nationally.
- A methadone mobile clinic to visit all hostels and day care centres in city locations with an identified problem of drug use on a systematic basis.
- The provision of day care services in all emergency hostels and the national phasing out of "bed only" hostels.
- Funding for sheltered work projects, including occupational therapy for persons unlikely to achieve full integration into the workplace.

Recommendation 10
Health Boards to enter into dialogue with prisons, hospitals and other institutions, so that the institution's discharge policies are altered, leading to people no longer discharged without proper planning and placement.

As part of the achievement of this target, the existing accommodation of people entering institutions should be actively secured in order to prevent homelessness on discharge.

Recommendation 11
To overcome the poor coverage with medical cards, special medical cards should be used for homeless people that do not require that an address be used.

Easy registration should be the underlying principle. Contact with the health services should be used as opportunities to determine medical card status and to initiate the application process where appropriate.

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Recommendation 12
The establishment of monitoring mechanisms to assess the effectiveness of the measures taken to improve the health of people homeless.

There are a number of ways of measuring ill health. In the Simon Community's view, the best mechanism to measure the effectiveness of the measures in improving homeless people's health is through comparing Standardised Death Rates (SDR) of homeless persons relative to the general population. Measuring the changing SDR of people homeless and comparing this with the SDR of the general population would over time reveal exactly whether the measures taken are having the desired effect.

2.3 Co-ordination of health and housing policies

There is an important interaction between levels of good health and good housing conditions. This occurs in two ways:

- The physical conditions of the house and where the house is located impact on the inhabitant's health.
- Community based health and support services help reduce the exclusion of those living in disadvantaged housing. In particular, timely health and support services help the most vulnerable maintain their housing and stop them becoming homeless.

The UK Government's Acheson Report[20] traces the roots of ill health in the majority of cases to social and environmental factors. The UK Government has supported the findings of the report. The Minister for Public Health in the UK, Tessa Jowell has stated that, "for this government, the health of the individual cannot be separated from the surrounding environment".

The UK Government has introduced a number of developments in light of the report. One of the more innovative is the introduction of Health Action Zones. Health Action Zones are partnership projects between the National Health Service, local government and local communities. The Zones have been established to develop partnerships that will harness the energy of local communities to reduce health inequalities. Of 59 projects that have received funding since 1998, four have a specific housing and health focus.

An example of the work facilitated by Health Action Zones is Leicester Health Action Zone's financing of a project which will create infrastructure, protocols and procedures to ensure the seamless delivery of a wide range of

[20] Independent Inquiry into Health Inequalities, commissioned by the UK Government in 1997 from Donald Acheson

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support services to benefit those experiencing, recovering and at risk of ill health.

Recommendation 13
The Departments of Environment and Health come together to work on possible areas of synergy and set out clear parameters for their work.

It appears to us that Government departments are not co-ordinating their work to maximum effect. In particular the possible synergies between the work of the departments of Health and Environment have been lost. As part of any joint working, we propose that:

- The housing section in the Department of the Environment has a health specialist who can advise on health best practice for the development of all new housing.
- Clear lines of responsibility and clear funding arrangements are demarcated for the management and support needs of vulnerable groups, especially those mentally ill and homeless.

Recommendation 14
The Irish Government borrows for the experience of the UK Government in its introduction of Health Action Zones and makes improvements in health a component of its RAPID regeneration programmes.

We propose that "Health Zones" should be introduced in line with the RAPID programmes to be operational in the most marginalized areas in Ireland. Each Zone should have a set period, typically of between 5 to 10 years, in order to encourage a more long-term approach to planning.

Recommendation 15
Clear streams of funding are identified in housing management for the support needs of individuals needing greater support.

Although outside the competence of the Department of Health as it is presently constructed, we include here a call for reform of the Capital Assistance and Rental Subsidies Scheme so that they cover the full costs involved in providing supported housing for people who are mentally ill and homeless. An increased and identified stream of funding for the management of the property and support needs of the individual is also critical if the capacity and role of voluntary organisations is to be maximised and the needs of people mentally ill and homeless are to be met.

In conclusion

The Simon Community of Ireland welcomes this opportunity to make a submission to the Department of Health on its Health Strategy 2001. We

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look forward to working with you and all other stakeholders to achieve greater access and better services for homeless people. Within this context we would hope to see:

1. The points we have outlined in this submission discussed in the review of the Health Strategy,
2. The hitherto neglected issue of the interaction of mental ill health and homelessness now prioritised,
3. Our specified recommendations adopted in the new revised Health Strategy.

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Recommendations: Summary Table

Care for those mentally ill and homeless

1. On grounds of principle and practice we believe that people who are mentally ill and homeless should, for the purpose of service provision, have their mental illness treated as their primary condition and their homelessness treated as their secondary condition.
2. Services to people mentally ill and homeless should be free from catchment area constraints.
3. An assessment of need of each homeless service user in the country should be undertaken so that the needs of each person mentally ill and homeless is fully assessed and their needs are addressed.
4. By 2006, 500 additional accommodation places with support to be provided nationally, so that persons mental ill and homeless are not staying in unsuitable accommodation, either in acute care or in unsupported accommodation, which does not match their needs.
5. Full implementation of the Guidelines on Good Practices and Quality Assurance in Mental Health Services.
6. Mental health services provided as a right, based on the principle of reciprocity.

Treatment of other health problems experienced by those homeless

7. The fast introduction of multidisciplinary primary care teams working exclusively with persons homeless.
8. The provision of sufficient residential treatment places for drug addicts and alcoholics, which reflect the diversity of this client group and the diversity of their needs.
9. Additional named specific resources to be dedicated to improve the health of people homeless.
10. Health Boards to enter into dialogue with prisons, hospitals and other institutions, so that the institution's discharge policies are altered, leading to people no longer discharged without proper planning and placement.
11. To overcome the poor coverage with medical cards, special medical cards should be used for homeless people that do not require an address.
12. The establishment of monitoring mechanisms to assess the effectiveness of the measures taken to improve the health of people homeless.

Co-ordination of health and housing policies

13. The Departments of the Environment and Health come together to work on possible areas of synergy and set out clear parameters for their work.
14. The Irish Government borrows for the experience of the UK Government in its introduction of Health Action Zones and makes improvements in health a component of its RAPID regeneration programmes.
15. Clear streams of funding in housing management are identified for the support needs of individuals needing greater support.

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