Simon Communities of Ireland

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Submission to

The Expert Group on Mental Health Policy

December 2003

Published by:
SIMON COMMUNITIES OF IRELAND
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Background

The Simon Communities of Ireland is the federation of six communities in Cork Dublin, Dundalk, Galway, the Midlands and the South East. Simon has been working with and on behalf of people who are homeless in Ireland for over thirty years. The issue of mental health and homelessness has been of key concern to our organization for a substantial period of time and we very much welcome the opportunity to submit to the Expert Group on Mental Health Policy. We hope that in the formulation of new national policy every effort will be made by the Expert Group to take into consideration the views of people experiencing mental ill health themselves, and in particular the views of people experiencing both mental ill health and homelessness.

This submission will cover the following areas:

- **Homelessness in Ireland**

A synopsis of figures, causes and impact

- **Central issues in mental health and homelessness**

Gleaned from interviews with members of the Simon Communities, health professionals and policy makers

- **Policy Audit**

Synopsis of key policy changes / lack of policy progression in the area of mental ill health and homelessness.

- **Recommendations**

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Homelessness in Ireland

There are currently at least 4,176 adults and 1,405 children experiencing homelessness as per the statutory definition. This figure has increased by 274% since official recording began in 1989. Homelessness is usually caused by the experience of some form of personal crisis - such as a relationship breakdown or bereavement, or physical or sexual violence in the home combined with the experience of poverty. Young people leaving care, people leaving prison and other institutional settings are also particularly vulnerable to becoming homeless.

The age and gender profile of people who are becoming homeless has substantially altered in recent years, with more women and young people seeking services. The numbers of two parent families experiencing homelessness has also grown indicating that the direct structural effect of the price of accommodation on homelessness is increasing.

People experiencing homelessness 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 has tabulated the incidence of general health problems among people experiencing homelessness. It found that they have a much higher prevalence of chronic physical disease, mental ill health and a lower life expectancy than those of comparable age in the general population.

According to research from Crisis in the UK , the average age of death of a homeless person sleeping rough is 42 years. From Simons experience of working with street homeless in Cork, Dublin, Dundalk and Galway the mortality rates of rough sleepers in Ireland are along similar lines.

Since the first assessment in 1989, the official homelessness figures have increased by 274%.

Year	Total Numbers Assessed
1989	1,491
1991	2,371
1993	2,172
1996	2,501
1999	5,234
2002	5,581

Some of this increase can be attributed to better practice at a local authority level in terms of assessment mechanisms. However it is worth noting that a substantial data deficit still exists. This was thrown into sharp relief with the production of the 2002 figures (which were not published until 14 months after the official count).

In the period between the 1999 figures and the 2002 figures each local authority was mandated under the Governments Homelessness Strategy, "Homelessness an Integrated Strategy" to assess and meet the needs of those experiencing homelessness in their area and to do so in conjunction with the voluntary service providers. (This strategy, while extremely welcome, highlights the inadequacies of the 1988 legislation). While the methodologies employed in the creation of local homeless action plans is different to that in the official assessment, the anomalies between the two sets of date display an even more extreme

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homelessness crisis than the official figures document. Among these anomalies is the number of local authorities that recorded a complete elimination of homelessness in their official figures in 2002, yet their action plans identify the need for substantial services.

The official data continues to provide merely a head count, giving no estimation of the type of housing needs required by those counted. (There is no formal analysis in terms of age, gender, dependant children, physical / psychological disability etc on which to asses the type of housing services required).

The official data on homelessness is not only qualitatively insufficient but is also more than likely fundamentally quantitavely flawed. The true extent of the homelessness crisis is undoubtedly much more extreme than the current limited data portrays.

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Major Issues

The high prevalence of mental ill health among the homeless population and the inadequacy of responses to meet these needs has been an issue for the Simon Community for more than 20 years. Only more recently has the issue been identified by statutory service providers as a significant problem and even then considered policy responses have been few and very slow to implement. The major problems highlighted by our service providers, from their experience of the system, are:

Substance misuse and psychiatric service have been reluctant to manage patients with a dual diagnosis as neither sees it as their responsibility. People who are homeless with a dual diagnosis are often subject to a defensive service provision where it is easier to assume care is someone else's responsibility. Access criteria, whereby a person must be drug or alcohol free before they can access mental health services further marginalizes dual diagnosis clients.

While there are services for people with severe and enduring mental illness, little work is done with people with low-level mental health problems. Low-level mental health problems, while harder to identify, are nonetheless very distressing for a person concerned and often leave them with vulnerable and chaotic lifestyles. The lack of active day rehabilitation programmes for those recovering from a bout of mental illness is an identifiable weakness in the existing provision of services. Such programmes have a beneficial effect in helping people re-learn life skills that are lost during a period of illness, encouraging social integration and preventing relapse.

The operation of a catchments area system makes it difficult for people who are homeless to gain access to assessment and treatment. The problems caused by catchments areas for people who are homeless continue to persist in many areas. While the concept developed as a positive, to identify and not to lose people, it has not worked effectively for people without an address and when services are under pressure in an area, it provides an excuse for refusing to offer treatment and support.

The lack of choice is also stigmatising to those who suffer from mental illness, since those with physical illness can exercise a choice of where they present for treatment and care. The Irish Medical Organisation AGM in April 2001 unanimously passed a motion calling on the Department of Health and Children to review this policy.

There is a critical shortage of necessary supported housing and community supports for people with mental ill health.

This remains the biggest problem for homeless service providers. The European Observatory on Homelessness has found that Ireland has one of the lowest levels of supported housing for people who are homeless compared to other European nations. Homeless services have tended to concentrate on basic needs and have not built up expertise in the area.

There are also a considerable number of people 'at risk of homelessness' who are not getting the support or access to supported facilities that are necessary. From correspondence with the South Western Area Health Board the following information has become available:

The numbers of people at risk of homelessness who have been housed in supported housing units by the South Western Area Health Board (Dublin based) during 2000, 2001 and first part of 2002 in their facilities was 60 and the total number housed by local authority/voluntary sector housing over the same period was 35. In total the South Western Area Health Board manages 3 high support facilities for a total of 43 people, 3 medium

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support facilities for 43 people and 6 residences rented from local authorities for 32 people, very low in comparison with the existing need. The Inspector of Mental Hospitals has also questioned the quality of the "supported" accommodation offered by Health Boards.

A 'shortage' of acute psychiatric beds

In theory this is directly responsible for a number of problems including difficulty in securing acute beds for admission for someone who needs this type of support, and the unplanned discharge of patients because of the pressure on existing beds.

The Health Research Board analysing the problem in the Eastern Regional Health Authority, (referred to in the report 'We have no beds'), finds that 45% of the acute psychiatric beds are occupied by non-acute patients and that 20% of people are staying for a year or more in acute beds because there are few move on options, both factors blocking up the system. The Research Board concluded that, "The current level of psychiatric bed provision is sufficient if the range of community support services (particularly residential services) is extended considerably." They also highlight the "shortage, in some cases a virtual non-existence, of rehabilitation places for 'inappropriate' patients" and "an uneven available and responsiveness of alcohol services across the EHB area".

While published in 1999, few if any of the many recommendations of the report have yet been implemented, the report is still highly relevant today, and its recommendations are applicable to other health board areas and not just the Eastern Region.

In support of the Health Research Board report, Brian Harvey comments in a report for Homelessness and Mental Health Action that, "the rise in homelessness from the 1980s has often been linked to the de-institutionalisation of psychiatric patients into the community. In Ireland the evidence is less that discharged former long-stay patients become homeless but rather that the reduction of long-stay beds closed off what in effect was a residual social accommodation role performed by long-term psychiatric institutions".

Patients routinely discharged into homelessness when their mental illness is not longer acute.

Our service providers believe that they are being used as a "dumping ground" by the mental health services, who send people presenting with mental illness to homeless hostels because the person and (it is claimed) the health service have not other option. A recent case was of a man discharged into the Cork Simon shelter from a psychiatric service who was in a wheelchair and still attached to an IV system.

(The Department of Health counters that from research they completed in 1992 tracing patients discharged from Mental Institutions, none of those discharged became homeless). It may be the case that many people which the Psychiatric service classifies as having behavioural difficulties but not mental illness and therefore not part of their responsibility are finding their way into the "homeless met"while previously the would have been housed in Mental Institutions.

This movement into homelessness for the person with moderate mental illness/ behavioural difficulties is not likely to prove successful for the individual. He or she is transferred into a chaotic environment, with easy access to prescription and non-prescription drugs and with few if any trained and knowledgeable mental health professionals to offer support. Many homeless services have reacted angrily to this development, with many claiming they cannon cope with the behavioural and other problems presenting by people with mental ill health and some service providers denying them access.

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Recent Policy Changes:

The National Health Strategy

The Health Strategy, Quality and Fairness: A Health System for You makes only three mentions of the homeless in the whole of the document. Of these, only one deals with mental health and the homeless.

In the broader question of mental health, the strategy acknowledges that the provision of care in the community has not been successfully implemented. In particular it notes that there are few multidisciplinary health teams in operation and few psychologists, social workers or occupational therapists employed. It states that, "While considerable progress has been made in many health board areas in implementing the change from institutional to community-based care, few have as yet competed the process". (This is nearly 20 years on from the Department of Health strategy in 1984, "Planning for the Future"), The Health Strategy goes on to state that, "Despite some progress in recent years, the existing level of services is inadequate".

The Health Strategy also recognises that the overly medical approach to mental illness in the past does not allow for a wider view of mental health, stating that policy and objectives need to be updated to deal with such issues as "concerns about using only the traditional 'medical' model of care for mental illness rather than considering alternative therapies such as psychotherapy or psychology treatments."

In the separate National Strategy for Primary Health Care published at the same time, Mental Health Ireland finds that the plans in the strategy for mental health care within primary health care are weak and underdeveloped. While primary care health service delivery is generally changing, the strategy offers no clear direction for mental health professionals.

"Homelessness - An integrated strategy"

"Homelessness - An integrated strategy" undertakes that all health boards carry out a mental health needs assessment and develop appropriate responses. It is unclear to date if any Health Board has actually carried out a complete needs assessment and developed appropriate responses in their area. The Strategy committed that a comprehensive mental health strategy for people who are homeless would be initiated. This has never come into fruition, and the measures proposed under the Homeless Preventative Strategy do not constitute major progress in the area.

Homeless Preventative Strategy

According to Government figures, there were 4,768 patients in psychiatric hospitals (public and private) and acute units at the end of 1999, a drop of over 4,700 on the numbers of people help in 1989. Over the same period the numbers of places available in "Hostels for the Mentally Ill" increased by less than 700. This is striking in the light of the lack of undertakings in the Preventative Strategy for new community based supported housing for people who are homeless discharged from psychiatric hospitals and those presently staying in homeless hostels where their support needs are not being met.

Actions to be undertaken under the Preventative Strategy include:

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- All psychiatric hospitals/units will have a formal and written Discharge Policy, which set out minimum standards for discharge. (The Discharge Policy does not state that if the person being discharged does not have suitable accommodation in which to live after discharge then discharge should not take place)
- Every psychiatric team will have a nominated professional to act as Discharge Officer.

The preventative strategy than makes a number of recommendations involving the "Multi-Disciplinary Team" regarding liaison with the Discharge Officer and the drawing up of a post-discharge care plan. Although the recommendations have some, albeit limited relevance to the situation in Dublin, where a Multi-Disciplinary Team for the Homeless has been set up (although not yet fully operational), these recommendations have no relevance to all other parts of the country where no Multi-Disciplinary Teams exist. It seems a remarkable oversight for a National Preventative Strategy that no reference to follow up procedures is made to the situation for people discharged into homelessness in areas outside of Dublin.

Overall the strategy focuses on procedural changes in the operation of statutory services, which although welcome, cannot in themselves be classified as comprehensive prevention.

Report of the Inspector of Mental Hospitals

According to the Report of the Inspector of Mental Hospitals of October 2002, reviewing the operation of the system up to December 2001, hundreds of patients are being housed in Irish mental hospitals not because they need help with their mental illness but because they are old or homeless and have no where else to go. The report states that "many, but not all of these older persons now show little sign of behavioural disturbances related to psychiatric disorder - their needs and their disabilities relate to their age". The Inspector of Mental Hospitals urges their transfer to community residences where that is possible. The Inspector also finds "a large number of current psychiatric inpatients who are homeless and are accommodated in acute or long-stay hospital wards despite being suitable for community residential placement. There is hardly a service in Ireland where this is not a current issue".

The Inspector found poor conditions in many hospitals throughout the country and recommended that a number be closed. The conditions of some of the residences which are owned by the Health Boards and which are used to house patients in a community setting also came in for severe criticism.

Dublin Homeless Action Plan

Shaping the Future, the Homeless Action plan for Dublin states that "The General Manager for Homeless Services will establish a working group of homeless service providers, Directors of Mental Health in each Health Board and other relevant personnel by September 2001, to draw up a plan". A further action point states that, "The plan will be implemented with effect from March 2002 and reviewed on a 6 monthly basis. Services to be reviewed include adult and child psychological, psychiatric, counselling and other non-medical interventions. It will provide for protocols to deal with people outside of the established catchment areas and arrangements for the transfer of files between institutions and areas". The plan was also to make proposals for the improvement of services and arrangements for monitoring and evaluation.

By November 2001, the Agency "will have commissioned and completed a study into the best way of meeting the needs of people who are homeless for counselling and have implemented proposals from January 2002".

Performance indicators for successful implementation include:

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- The numbers of people who are homeless with a mental health problem
- The wait time for drug and alcohol detoxification.

Progress in relation to the timescales originally set out has been slow, however the Agency have appointed a member of staff specifically on the area of mental health and integrated advocacy. She is currently auditing the services available and system blockages and her report, which is due in early 2004 should be very instructive.

Expenditure

As can be seen from above there have been numerous recommendations, some with considerable merit, made in various reports, plans and strategies in the last two years. In the opinion of Mental Health Ireland, if all these recommendations were implemented fully then practice would be radically different today. However there have been considerable delays in implementation, the main delay factor being finance.

Dr. Marcus T. Webb writing in the Psychiatric Nurses Journal in 1993 stated that, "The share of gross expenditure provided in Ireland for the psychiatric services has been reduced by 20.7% since 1976. This slide must be halted and reversed if this country is to preserve a semblance of mature and civilised care for its mentally ill". Recent ERSI statistics show that, rather than following this advice, revenue expenditure in mental health care and treatment as a proportion of total health spending has fallen from 9.5% of total spending in 1995 to 7% today.

While overall growth in Irish Health expenditure in the eleven years between 1990 and 2001 was approximately 300% (the greater proportion of this is increased salaries to nurses, doctors and consultants), that of the psychiatric programme was just 131% by far the lowest of any health programme. In March 2001, the Irish Psychiatric Nurses Association commented that the mental health services are the "first in line for cutbacks in time of financial stringency and the last to benefit in times of plenty".

Improved practice

Throughout the country there have been some important improvements in the past three years, these have mainly come about as a result of increased partnership and communication between statutory and voluntary services providers. For example in Dundalk CPN visits the Simon Community House fortnightly to attend to long-term residents. A team, including a consultant psychiatrist, will come to the Community House in response to staff concern. Admission to hospital can be processed very quickly as a result of good liaison between Simon and Mental Health Services. A consultation process including health, housing, and voluntary sector representatives, set up by the Director of Homeless seeks to find the most appropriate response to a variety of situations. Business is conducted on a case-to-case basis. Of recent, issues addressed included acquiring appropriate accommodation prior to discharge, temporary admission and planned discharge, an ongoing support & observation. This type of liaison must be ameliorated and mainstreamed.

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Key Recommendations

- The development of a rights based approach to mental health provision for people who are homeless or at risk of homelessness, integral to this approach should be a holistic assessment mechanism, an appeals mechanism, timeframes for the delivery of services and choice and quality in service providers. This approach should be underpinned by legislation that gives full effect to Ireland's international human right obligations.

- The naming of people who are homeless and people at risk of homelessness as a specific target group within Government health services.

- Legislation to put the homeless action plans on a statutory basis.

- An investigation into the best models of supported housing available, and the development of model for state funding of the capital and current costs for these initiatives on an ongoing and equitable basis.

- A proactive policy of including those inappropriately housed in hospitals and other institutions in the housing needs assessment.

- A strategy for re-housing all those currently inappropriately in hospitals and mental health institutions.

- Catchment area services should be appropriately resourced and adapted, and relevant staff trained to meet the particular needs of their homeless populations in both in-patient and community-based settings, so they are enabled to access a comprehensive range of services.

- Accurate data on the number and mental health needs of homeless adults and children should be regularly compiled.

- The particular high level of mental health care needs of Ireland's urban homeless population should be addressed, by ensuring a comprehensive provision of specialised homeless mental health services, with an adequate number of specialist in-patient acute beds, full mental health multidisciplinary teams, and outreach services, with appropriate supports.

- Particular attention should be given to the services available to homeless children, and those living in, and leaving, state residential care.

- Integrated mental health programmes should be developed for people who are homeless with a dual diagnosis of mental illness, and alcohol or substance misuse and/or intellectual disability.

- The review of Homelessness An Integrated Strategy and the Homeless Preventative Strategy committed to in the NAPS/incl (due before the end of 2003) should be independently undertaken, take on board the terms of reference proposed by the Simon Communities of Ireland, Focus Ireland, St. Vincent de Paul and Threshold, engage with homeless service providers and be initiated immediately.

- A public education and awareness programme to counter the stigma of mental illness should be initiated, emphasising the rights of people with mental illness.

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- Rights-based mental health legislation giving full effect to Ireland's international human rights obligations should be enacted.

- A comprehensive and adequately resourced system of personal advocacy, to assist people who are homeless with mental illness to assert their rights in a manner consistent with MI Principles 12(1) and (2) should be provided.

- Family support and information services should be made widely available.

- Garda training in mental health needs and practices with particular emphasis on the needs of people who are homeless, should be introduced.

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