Submission to
the Joint Committee on the Future of Mental Health Care

January 2018

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Introduction

The Simon Communities in Ireland welcome the opportunity to make a submission to inform the work of the Joint Committee on the Future of Mental Health Care. There is a complex relationship between homelessness and health incorporating physical health issues, mental health issues, problematic drug and alcohol use and complex needs.[1] Health issues can be the cause of homelessness occurring in the first place but they can also be a consequence of the experience of being homeless. What is clear is the longer a person is homeless the greater the impact on their overall health and wellbeing. People experiencing homelessness are not a homogenous group. They are a diverse group of people that include women, young men, families, those with complex mental and physical health needs and people with problematic drug and alcohol use. Understanding this diversity and individual's unique pathways into and experiences of homelessness is crucial to ensure we can respond to their individual and often complex health needs.

General health of the homeless population: Census 2016 Data:

Of the 6,906 people enumerated as homeless on Census night 2016, 61.9% indicated that their general health was 'Very good' or 'Good'. The corresponding figure for the entire population was 87%. On the other hand, 18.8% of people who were homeless had health which was 'Fair', 'Bad' or 'Very bad' compared with 9.6% for the general population. women in the homeless population had better health than men, with 67.6% of women describing their health as 'Good' or better compared with 57.8% of men. As with the overall population, general health tended to decline among older age groups in the homeless population. In the age group 15 to 24 the results show that 72% had 'Very good' or 'Good' health. In contrast, 38.5% of those aged 55-64 had 'Very good' or Good' health.

Recommendations

General

- Acknowledgment of the causal relationship between homelessness and physical and mental ill health.
- People who are homeless should be named as a target group in health and mental health policies and strategies.

Housing First

- To support the long overdue extension of Housing First nationwide, put in place and maintain funding for Assertive Community Treatment (ACT) Teams including mental health provision. The urgent implementation of commitments in *Rebuilding Ireland* to support this.
- Prioritisation and targeting of people who are homeless and those with complex support needs particularly rough sleepers and people who are chronically homeless with complex and compound health needs.

Primary Care

- Introduce universal access to primary care and GP services in line with the recommendations contained in the *Sláintecare Report.*
- Increase access to general practitioner (primary healthcare) services to meet the healthcare needs of people who are homeless and to provide early intervention to prevent further chronic illness.
- The extension of counselling in primary care provided by private providers through GP/primary care referrals and the development of public psychology services in primary care must be actioned as a matter of priority.
- Urgent implementation of the commitment to deliver an agreed stepped model of care for people experiencing homelessness with mental health issues.

[1] A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing (Turning Point, 2014) http://www.turning-point.co.uk/media/636823/appg_factsheet_1_-_june_2014.pdf.

- Improve health outcomes for people with dual/multi diagnosis by ensuring greater collaboration between drug and alcohol services and general mental health services.
- Develop onsite counselling/psychological services in homeless accommodation services to provide trauma informed care. Establish targeted trauma informed responses to deal with the complexity of need for women who experience homelessness with complex needs.
- Ongoing resourcing for primary care services and interventions in homeless services where required nationwide. There are some excellent examples of such initiatives in operation in the Simon Communities.
- Resource the delivery of step up/step down beds for people who are homeless being treated for chronic illness.
- Develop 'Specialist Adult Teams' to manage the combination of complex and problematic drug and alcohol use and mental health issues as recommended in *A Vision for Change'* and the *National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self Harm* and ensure interagency responses.
- Provide for a dedicated counselling service to provide out of hours outreach support to clients in homeless accommodation services who are expressing suicidal ideation.
- Monitor, record and respond to breaches of discharge protocols in hospitals and prisons for people who are homeless being discharged back into homelessness.

Funding

- Increase non-capital mental health expenditure to 10% of the total health budget as recommended in the *Sláintecare Report.* This should include the dedicated ring fencing of funding streams for the full implementation of the commitments contained in '*A Vision for Change*'.
- We fully support the costed primary care and mental health recommendations contained in the *Sláintecare Report* and urge the Joint Committee to adopt these in full and revise funding upwards where appropriate.
- Funding must be provided to urgently implement the *Sláintecare* recommendations to develop child and adolescent mental health teams, adult community mental health teams, old age psychiatry services, child and adolescent liaison services and intellectual disability mental health services.
- We call for the full delivery of the Budget 2017 commitment of €6 million for the provision of additional care and case management assessment and intensive addiction and mental health programmes for people using homeless services.

Recruitment

- Implement the *Vision for Change* recommendation that staffing levels across the mental health services be increased to at least 12,000 staff in post.
- Staffing levels must be addressed to fill significant mental health service gaps that are impacting on particularly vulnerable groups e.g. Self-harm nursing staff in A&E departments.
- The proposal in the *Implementation Plan on the State's Response to Homelessness* to provide a dedicated Community Mental Health Nurse in each ISA[2] area to support the needs of people who are or at risk of homelessness needs to be actioned. This is supported in the *Report of the Committee on Housing and Homelessness* (2016).
- Increase incentives and access for GP's to encourage them to become level 2 GP's under the Methadone Protocol[3] for methadone prescribing and methadone management.

[2] ISA – Integrated Service Areas are Community based health services outside acute hospitals for people with low-medium level of need in primary care, social care, mental health and health & wellbeing.
[3] http://www.drugsandalcohol.ie/6721/2/Butler_1983_The_Making_of_the_Methadone_Protocol.pdf

Mental Health Service Performance Indicators

- Key performance and outcome indicators must be developed in line with the development of the stepped model of care for people experiencing homelessness with mental illness.
- Specific key performance and outcome indicators must also be developed to capture the performance of mental health services for specific demographics within the homeless population.
- Existing social inclusion performance indicators as they relate to people experiencing homelessness should be expanded and where possible outcomes measured.

About Homelessness and Health

Mental health

Mental health issues can be a reason for people becoming homeless in the first place while the experience of being homeless can affect a person's mental health, deteriorating the longer a person remains homeless. A recent study on the health of people experiencing homelessness *Homelessness: An Unhealthy State* found that 58% of the study participants had at least one mental health condition.[4] Of a sample size of 596 participants:

- 52% were diagnosed with depression with 44% being treated for their depression.
- Thirty-nine percent of respondents were diagnosed with anxiety with 32% receiving treatment.
- Thirteen percent of participants had self-harmed in the past 6 months while 24.7% had self-harmed prior to the past six months.
- Twenty-nine percent of participants had attempted suicide in the past six months while 28% had attempted suicide prior to the past six months. In acknowledgement of this, the National Office for Suicide Prevention 2020 strategy identifies people who are homeless as a priority group.

A recent study by the Royal College of Surgeons in Ireland and Safetynet, *Health and use of health services of people who are homeless and at risk of homelessness who receive primary healthcare in Dublin* further supports these findings.[5] The majority of the 105 study participants in that study had at some point received a formal diagnosis of a mental health issue (70%) including depression (50%), addiction disorder (39%), anxiety (36%), schizophrenia (13%) and bipolar disorder (6%).

Problematic drug and alcohol use

Problematic drug and/or alcohol use can put people at an increased risk of homelessness, and can also be a result of traumatic experiences, including homelessness. *Homelessness: An Unhealthy State* found there was a rise among participants in problematic drug and alcohol use in particular, as well as a dramatic rise in dangerous drinking among women who were homeless, a rise in illicit use of benzodiazepines, while poly-drug use among participants became the norm with a high use of prescribed sedatives. Cannabis was the drug most commonly used among current drug users followed by illicit use of benzodiazepines and heroin. Some of the Simon Communities have seen an increase in the use of opiate drugs, prescription drugs (in particular, benzodiazepines) and synthetic benzodiazepines drugs in recent times. A 2011 Simon Communities Snapshot Study Report found that over 50% of respondents reported that they were current alcohol users, while 31% reported that they were current drug users.[6] That health snapshot study found that alcohol use was highest among respondents living in high-support housing and emergency accommodation. In addition, it also found the highest level of drug use was among people sleeping rough and those using emergency accommodation.

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

[5] http://epubs.rcsi.ie/cgi/viewcontent.cgi?article=1079&context=gpart.

[6] Simon Communities in Ireland & Kathy Walsh, *'Simon Snapshot Report 2011'*, P.28, http://www.simon.ie/Portals/1/Simon's%20National%20Health%20Snapshot%20Study%20Report%202011.pdf.

Dual/multi diagnosis and complex needs

A person who is homeless may have multiple needs or complex needs[7], such as problematic drug and/or alcohol use, mental health difficulties, physical health difficulties, personality or behavioural disorder, challenging behaviour and vulnerability. If one issue were to be resolved, other issues would still be cause for concern (Homeless Link, 2002)[8]. This can make it very difficult for people to navigate all the various services they may need at one time. *Homelessness: An Unhealthy State* found that 47% of participants had a mental health diagnosis and a self-diagnosed drug and/or alcohol problem. Thirty-five percent of participants had a mental health diagnosis and current illicit drug use. People with dual diagnosis can find it very difficult to access services as they often fall between two stools with mental health services suggesting they deal with their drug issue first and vice versa. International best practice argues that the two issues be treated at the same time and in a co-ordinated way.

The Simon Communities' '*Women, Homelessness and Service Provision'* (2015) research captured 60 female participants' varying circumstances at the point of becoming homeless. On becoming homeless, the perceived stigma of homelessness led to many women avoiding contact with homelessness servicers often for periods of months or longer. Such periods of hidden homelessness served to compound existing problems, placing women in situations that often further diminished their physical and mental health. On eventual access to homeless or domestic violence services, women had frequently reached a crisis point in their lives and the clear majority had multiple, complex needs.[9]

Disability within the homeless population

The proportion of persons with a disability among the homeless population recorded in Census 2016 was higher than for the general population. A total of 1,871 persons had a disability, representing 27.1% of the total, in contrast to the general population where the rate was 13.5%. The most common type of disability among the homeless population was a difficulty with pain, breathing or another chronic illness or condition, accounting for 12.2% of homeless persons. A further 11.9% had a psychological or an emotional condition, with 9% indicating either a difficulty working at a job or business or attending school/college or a difficulty learning, remembering or concentrating.[10]

Adverse childhood experiences of homelessness and adult mental health

It is increasingly recognized that many people who are at risk of or are experiencing long term homelessness have been exposed to trauma.[11] Trauma is prevalent in the narrative of many people's pathways to homelessness and during their experiences of homelessness. Homelessness itself can be considered a trauma in multiple ways. The loss of a home together with loss of family connections and social roles can be traumatic. This is because "like other traumas, becoming homeless frequently renders people unable to control their daily lives".[12] According to Eisenberger et al, social exclusion activates the same neurological systems as physical trauma, with a similar impact on people.[13] Added to this, homelessness can be such an additional stress in the life of a person that it can erode the person's coping mechanisms and the stress that it causes can rise to a level of trauma.

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[7] A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing (Turning Point, 2014) http://www.turning-point.co.uk/media/636823/appg_factsheet_1_-_june_2014.pdf.

[8] As cited in Feansta Health Working Group paper (2013) *'Health and Well-Being for All Holistic Health Services for People who are Homeless'.*

[9] Mayock et al, '*Women, Homelessness and Service Provision*', 2015, Simon Communities in Ireland, P. 53. http://www.simon.ie/Women_Homelessness_and_Service_Provision/#/1/.

[10] Census of Population 2016 – Profile 5 Homeless Persons in Ireland, http://www.cso.ie/en/releasesandpublications/ep/p-cp5hpi/cp5hpi/hpi/.

[11] FEANTSA, '*Recognising the Link between Trauma and Homelessness*', January 2017, P.1, http://www.feantsa.org/download/feantsa_traumaandhomelessness030734712190529468107 38.pdf.

[12] Goodman et al, '*Homelessness as psychological trauma. Broadening Perspectives'.* American Psychologist, Vol 46(11), November 1991, Pp. 1219-1225.

[13] Eisenberger et al, 2003: Does rejection hurt? An fmri study of social exclusion' in Science Vol 302, p290-292, accessed at www.sciencemag.org and Kross et al, 2011, 'Social rejection shares somatosensory responses with physical pain', in PNAS Vol 8;15, p6270-6275, accessed at www.pnas.org/cgi/doi/10.1073/pnas.1102693108.

In 1998, Felitti et al carried out a national study to examine the impact of childhood trauma and adverse childhood experiences (ACEs) on healthy development and later life negative health related outcomes.[14] The study was the first of its kind to be carried out on a national scale and compiled results from over 9,500 patients across the United States who completed and returned a survey. This study has been replicated a number of times and results consistently indicate that exposure to toxic stress or trauma as a child is significantly correlated with deleterious adult health and social behaviours (Taylor et al., 2008). This ten item scale posits questions related to an individual's exposure (before the age of 18) to physical, emotional and sexual abuse, and other household dysfunction.

The study revealed that more than half of the respondents had reported at least one ACE therefore determining that exposure to early life trauma was relatively common. However analysis revealed that respondents with a score of 4 or more were at dramatically increased risk for negative health outcomes, and a dose response between the ACE score and risk for poor health experiences was noted (Feletti et al, 1998, Murogy et al 2013). Where there is a 4+ score, the likelihood of depression increases by 460% and suicide by 1,220%. More recently, a UCC ACE study among homeless service users in Cork revealed that there are significant levels of childhood trauma in the clients who participated in the research and that clients were experiencing a range of negative health related behaviours as a result of substance misuse, homelessness and associated behaviours.[15]

Housing First

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

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

There are two key aspects to the Housing First[16] approach - immediate provision of housing without pre-conditions or the requirement of housing 'readiness' and the provision of open-ended, support in housing at the level required, for as long as necessary. Clinical supports are a central component of the wider Housing First support system. The recovery oriented approach to clinical supports is designed to enhance well-being, mitigate the effects of mental health and addiction challenges and improve quality of life and foster self-sufficiency.[17][18][19] These approaches, once properly resourced and implemented, improve the outcomes and quality of life for people who are homeless, or at risk of homelessness in Ireland.

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[14] Fellitti et al, Relationships of Child Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults – The Adverse Childhood Experiences (ACE) Study, 1998, American Journal of Preventative Medicine, http://www.traumacenter.org/initiatives/Polyvictimization_Articles/Felitti,%201998,%20Relationship%20of%20Childhood%20Abuse%20and%20Household,.pdf.

[15] Dr Sharon Lambert and Graham Gill-Emerson, '*Moving Towards Trauma Informed Care. A Model of Research and Practice*.' July 2017, Cork Simon Community, http://www.corksimon.ie/wp-content/uploads/2017/10/Moving-Towards-Trauma-Informed-Care-Report.pdf.

[16] In 2014 research undertaken by Mental Health Commission of Canada as part of the *At Home/Chez Soi study*, the largest ever study examining the effectiveness of the Housing First approach compared with the traditional staircase approach. The study followed more than 2,000 people who were homeless over a two-year period across five Canadian cities. The findings were very clear: The Housing First intervention was twice as effective as the staircase approach in ending homelessness for people who had been long-term homeless with complex support needs. Furthermore, the intervention led to significant cost savings when compared with traditional interventions[16]. The key to the success of Housing First is its comprehensive model of support for the most 'hard core' people who are homeless with the highest level of needs.

[17] Nicholas Pleace, European Observatory on Homelessness/FEANTSA, *'Housing First'*, P. 22, http://www.feantsaresearch.org/download/housing_first_pleace3790695452176551843.pdf.

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

[19] Calgary Homelessness Foundation, *'The Cost Benefits of Housing First'*, http://calgaryhomeless.com/wp-content/uploads/2014/06/The-Cost-Benefits-of-Housing-First.pdf.

To date, emergency accommodation has formed the basis of Ireland's response to the homeless crisis including the use of private hotels, B&B's and emergency dormitory shelter beds. As a strategy, this fails to address homelessness effectively. Without the necessary supports in place, people experiencing homelessness are often unable to access or sustain a home or access support services. There can be issues accessing mental health services, attending primary health care facilities or utilising mental health housing programmes for active drug and/or alcohol users. People can be deemed ineligible for housing payments such as Rent Supplement, the Rental Accommodation Scheme or Housing Assistant Payment scheme if they had rent arrears in the past three years or a criminal record in the last two years. This runs contrary to the ethos of Housing First approaches and presents a real risk of institutionalisation for people in emergency accommodation.

Primary Care

Recent research has shown that improving access to primary healthcare services for people who are homeless has significant cost saving implications for health service providers. The aforementioned study by the Royal College of Surgeons in Ireland and Safetynet identified general practice as an important setting to meet the healthcare needs of people who are homeless and to provide an opportunity for early intervention. This has been shown to improve the health of people who are homeless and reduce hospital admissions, resulting in reduced overall cost to the healthcare system.

In 2006, the comprehensive policy framework for the delivery of mental health services in the State was published entitled '*A Vision for Change*".[20] The report, compiled by an expert group on mental health policy contains a dedicated section addressing the need to extend mental health services into the primary care realm. The section contains 11 specific recommendations detailing the steps that must be taken to ensure the expansion of mental health services into the primary care realm. The recommendations cover increasing access to a comprehensive range of interventions in primary care; the availability of mental health professionals in primary care; the need for greater training for primary care professionals and research on the prevalence of mental health issues in primary care. These were joined by a number of procedural recommendations including service user GP registration systems and the development of a consultation/liaison model to ensure formal links between community mental health teams and primary care units.[21]

In 2015, Mental Health Reform undertook an analysis of progress made in the implementation of these recommendations in the intervening nine years since the publication of *A Vision for Change.* This analysis found that 'there remain significant gaps at primary care level in the delivery of mental health supports'.[22] Of particular concern is the finding that 'the lack of training among primary care professionals, particularly GPs, is a significant obstacle to effective use of primary care'. The lack of basic data on the number of mental health professionals in primary care is of equal concern given their pivotal role in the delivery of an efficient mental health system by providing key treatments and limiting unnecessary referrals to specialist mental health services. The analysis further identified a gap in research on the presentation, detection and treatment of mental health difficulties at primary care level in Ireland leading to problematic service planning, workforce training, delivery and evaluation.[23]

[20] *A Vision for Change - -Report of the Expert Group on Mental Health Policy,* 2006, http://www.hse.ie/eng/services/publications/Mentalhealth/Mental_Health_-_A_Vision_for_Change.pdf.
[21] Ibid, P. 61.
[22] Mental Health Reform, *'A Vision for Change Nine Years On: A Coalition Analysis of Progress'*, P.20, June 2015, https://www.mentalhealthreform.ie/wp-content/uploads/2015/06/A-Vision-for-Change-web.pdf.
[23] Ibid.

In August 2016, the Simon Communities in Ireland made a comprehensive submission to the Oireachtas Committee on the Future of Healthcare.[24] In May 2017, we welcomed the publication of the Committee's *Sláintecare Report* and the recommendations on the expansion of primary care services.[25] In its future deliberations we encourage the Joint Committee on the Future of Mental Health Care to use these recommendations as its starting point. Universal GP and primary care access is the foundation on which the Committee's other recommendations must be implemented. The extension of counselling in primary care provided by private providers through GP/primary care referrals and the development of public psychology services in primary care must be actioned as a matter of priority.

Funding

To fully realise the comprehensive reform of mental health services in the State including their extension to primary care settings, a *Vision for Change* recommended that Government progressively increase non-capital mental health expenditure to 8.24% of all non-capital health funding based on 2005 figures. This figured was revised upwards in the *Sláintecare Report* to 10% of the overall health budget. In Budget 2017, the Government committed to a total of €853.7 million in mental health funding. As a percentage of the total health budget, this allocation amounts to only 6% of total spend, significantly short of the 2005 *Vision for Change* target and drastically short of the revised 2017 *Sláintecare* target. Budget 2018 provided an additional €15 million for mental health spending in 2018 bringing the total projected funding to €868.7 million. This funding represents only 5.7% (approx.) of the total projected spend for 2018. According to Mental Health Reform, this represents a significant reduction from 13% in the 1980's and does not compare favourably with funding levels in Britain and Canada (13%) and New Zealand (11%).[26]

We fully support the costed primary care and mental health recommendations contained in the *Sláintecare Report* and urge the Joint Committee to adopt these in full and revise funding upwards where appropriate. The government must act to introduce universal access to GP and primary care over a five-year period as outlined in the report. The attached cost of €720.6 million over this time period must be seen as a strategic investment in public health and wellbeing. At a bare minimum, the extension of counselling in primary care settings through private providers and the development of public psychology services in primary care must be prioritised. The total funding required to develop these services over a three-year period amounts to €11.6 million, a crucial investment that would allow for the hiring of an additional 114 assistant psychologists, 20 child psychologists and an online CBT resource.

Given the complexity of need that exists within the homeless population we fully support the recommendations to develop child and adolescent mental health teams, adult community mental health teams, old age psychiatry services, child and adolescent liaison services and intellectual disability mental health services. The total funding required for the development of these services over a five-year period amounts to €121.5 million. This significant investment would have beneficial health outcomes for the general population and would go some way to managing the trauma experienced by those experiencing homelessness. It is disappointing that Budget 2017 commitments to deliver additional funding for the provision of additional care and case management assessment and intensive addiction and mental health programmes for people using homeless services will fall €2 million short of the 2017 budgetary target of €6 million. People with the longest experience of homelessness and those with the most complex support needs must be prioritised for housing at the earliest opportunity. The Simon Communities know from

[24] Simon Communities in Ireland, 'Submission to the Oireachtas Committee on the Future of Healthcare', August 2016, https://www.simon.ie/Portals/1/Simon%20Communities%20Submission%20to%20the%20Oireachtas%20Committee%20on%20the%20Future%20of%20Healthcare%20Final%20PDF.pdf.

[25] Oireachtas Committee on the Future of healthcare, 'Sláintecare Report', May 2017, https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Oireachtas-Committee-on-the-Future-of-Healthcare-Slaintecare-Report-300517.pdf.

[26] Mental Health Reform, '*Pre Budget Submission 2018*', P.5, 2017, https://www.mentalhealthreform.ie/wp-content/uploads/2017/08/MHR-pre-budget-submission-2018.pdf.

experience and international evidence that this group is the most vulnerable to entrenchment in emergency shelters and rough sleeping with detrimental effects on their physical and mental health. We call for the full delivery of this commitment in 2018.

Recruitment

In the intervening period between 2008 and 2014 the total number of whole time equivalent staff in post across the health service fell by 7.2%.[27] The *Sláintecare Report* attributes this significant reduction in staffing levels to the recruitment embargo put in place in 2009 and the Voluntary Early Retirement Scheme introduced in 2010. In combination with the widespread use of new agency staff these measures were intended to significantly reduce costs to the overall health system but instead resulted in substantial losses in institutional knowledge and skills and the demotivation of remaining staff.[28] A recent study suggests that the costs of implementing these staffing measures including increased pension payments and agency staff costs could have allowed the Health Service to hire an additional 3,800 staff in post.[29]

As outlined in the *Funding* section above, recommended increases in non-capital mental health funding contained in the Sláintecare report are largely aimed at increasing staffing levels across vital mental health services. A *Vision for Change* recommended that staffing levels across the mental health services be increased to at least 12,000 staff in post. As of October 2017, there were 9,767 whole time equivalent mental health staff in post across the national mental health services, representing approximately 80% of the recommended staffing levels outlined in a vision for change.[30]

According to Mental Health Reform, since 2008, there has been a decrease of almost 800 mental health staff in post or approximately 7% of the total.[31] This decrease has not been evenly spread across the breadth of mental health services with some cohorts of the population being more adversely affected than others. Worryingly, mental health services targeted at children and adolescents are impacted to the greatest extent. According to a 2016 HSE report there was a total of 603.95 staff in all child and adolescent community mental health teams nationally, representing just 51.6% of the recommended staffing levels contained in a *Vision for Change*.[32] These worryingly low staffing levels are leading to gaps in mental health services for 16 and 17 year olds; increasing admissions of children to adult psychiatric units and reduced access for particular groups of children including those in the care and justice systems. These significant shortcomings must be urgently addressed in light of the impacted at-risk groups. Currently, there are 3,333 children living in emergency accommodation across the country,[33] in addition to the 6,206 children in care across the State as of October 2017.[34] Staffing for Community Mental Health Teams must be urgently increased to ensure that these at-risk populations have unfettered access to the vital mental health services they require to address the trauma associated with experiences of homelessness and any adverse experiences of the care system. This is vitally important given the linkages between childhood experiences of care and subsequent experiences of homelessness.[35]

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[27] Ibid 12, at P. 95.
[28] Ibid.
[29] Williams, D, and Thomas, S, (2017) The Impact of Austerity on the Health Workforce and the Achievement of Human Resources for Health Policies in Ireland (2009-2014), http://www.ispa.ie/images/seminars/conference_2016/conf2016_slides/Steve_Thomas2.pdf.
[30] HSE, 'Human Resources Report', October 2017, P. 19, https://www.hse.ie/eng/staff/Resources/HR_publications/HR-Report-November-2017.pdf.
[31] Mental Health Reform, '*Pre Budget Submission 2018 – Time to Catch Up on Mental Health Investment*', P.6, https://www.mentalhealthreform.ie/wp-content/uploads/2017/08/MHR-pre-budget-submission-2018.pdf.
[32] HSE, '*Delivering Specialist Mental Health Services',* September 2016, P.19, http://www.lenus.ie/hse/bitstream/10147/620156/1/specialistMHservices.pdf.
[33] DHPLG, Homeless Report November 2017, http://www.housing.gov.ie/sites/default/files/publications/files/homeless_report_-_november_2017.pdf.
[34] TUSLA, 'National Performance and Activity Dashboard', October 2017, http://www.tusla.ie/uploads/content/National_Performance__Activity_Dashboard_Oct_2017_Final.pdf.
[35] Mayock et al, '*Young People, Homelessness and Housing Exclusion*', 2014, p.69, https://www.focusireland.ie/wp-content/uploads/2016/04/Mayock-Parker-and-Murphy-2014-Young-People-Homelessness-and-Housing-Exclusion-FULL-BOOK.pdf.

Mental Health Service Performance Indicators

On December 20th 2017 the HSE published its *National Service Plan for 2018* (the Plan).[36] The plan contains the key performance indicators across the breadth of the services provided within the health service. It is encouraging to see an increased awareness in the Plan of the specific health needs of specific demographics within the homelessness population. HSE Social Inclusion services are a vital component of the wider health service and are crucial to the continued delivery of harm reduction services for people with problematic drug and alcohol use. The Simon Communities remain committed to working with statutory agencies in the delivery of these and other harm reduction and treatment services including needle exchange programmes and detoxification treatment and recovery programmes. We are further encouraged to see an acknowledgment of the HSE's role in the delivery of key commitments contained in the *Rebuilding Ireland: Action Plan for Housing and Homelessness* and the recently launched National Drug Strategy *Reducing Harm, Supporting Recovery – a health led response to drug and alcohol use in Ireland 2017-2025*. However, despite this express acknowledgement of the HSE's role in the delivery of primary care and specialist addiction and mental health services for homeless people, there remains a significant Budget 2018 shortfall that must be addressed. As mentioned above, this commitment must be delivered in full in 2018.

Providing fair, equitable and timely access to quality mental health services for people experiencing homelessness is vital to counter the continuing trauma experienced during and following periods of homelessness. We welcome the inclusion under *Corporate Goal Plan 2* of the commitment to deliver an agreed stepped model of care for people experiencing homelessness with mental illness.[37] This commitment and the resultant services must be matched with specific key performance indicators (KPIS's) outlined in the Plan. The 2018 Plan contains only two KPI's that reference the delivery of health services generally to the homeless population within the breadth of Social Inclusion Services. Although welcome, these KPI's simply require the measurement of the number and percentage of people admitted to homeless emergency accommodation hostels/facilities whose health needs have been assessed within two weeks of admission.[38] Furthermore, the reduction in the expected activity/target for 2018 has been revised downwards from the 2017 target of 1,272 people to 1,035 in 2018. In percentage terms, the target has been revised downwards from 85% in 2017 to 73% in 2018.

As mentioned above, the commitment to deliver a stepped model of care for people experiencing homelessness with mental health services must be matched with specific KPI's. Specific KPI's must also be developed to capture the performance of mental health services for specific demographics within the homeless population. The current Mental Health Service KPI's outlined in the 2018 Plan are the logical starting point in this regard and can be bolstered with additional outcome performance indicators. Homelessness specific outcome performance indicators would naturally include physical and mental health status in addition to drug and/or alcohol use indicators. Further outcome performance indicators could include housing status and employment/education status to measure the impact of improved physical and mental health.

Conclusion

People who are homeless can experience a range of health issues, which include but are not limited to, physical health issues, mental health issues, problematic drug and alcohol use and complex needs. People presenting to homeless services often display multiple or complex needs within these broad health categories. The prevalence of illness amongst people who are homeless is exacerbated by a lack of good quality housing and the absence of clinical and health supports in the home. People who are homeless often encounter other significant barriers to healthcare in the form of stigma, cuts to health/HSE budgets,

[36] HSE, National Service Plan 2018, http://hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf.
[37] Ibid, P. 38.
[38] Ibid, P. 109.

administration of service catchment areas and the lack of homeless specialist health services. Best practice indicates that improving access to primary care services has large-scale health benefits for people who are homeless in addition to cost saving implications for the health service as a whole. The cross-party *Sláintecare Report* contains the necessary costed recommendation to make universal access to primary care a reality. These recommendations need to be actioned and implemented fully as a matter of priority. The solutions to homelessness involve preventing people from becoming homeless and providing access to affordable, permanent housing with support, as necessary (Housing First). Critical to this is the provision of clinical support. We know this approach works and we know that it can transform the lives of people who are living in hostels, hotels and B&B's. We believe the work of the Committee can have a beneficial impact on the improvement of existing mental health services for people who are homeless and the delivery of future services that specifically target the myriad of homeless specific health issues identified in this submission.

About Simon Communities

The Simon Communities in Ireland are a network of eight regionally based independent Simon Communities based in Cork, Dublin, Dundalk, Galway, the Midlands, the Mid West, the North West and the South East that share common values and ethos in tackling all forms of homelessness throughout Ireland, supported by a National Office. The Simon Communities have been providing services in Ireland for over 45 years. The Simon Communities deliver support and service to over 11,000 individuals and families throughout Ireland who experience – or are at risk of – homelessness every year.

Whatever the issue, for as long as we are needed, Simon's door is always open. For more information please visit

Services include:

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

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Appendix 1: Housing First

Improved outcomes for people experiencing homelessness

The 2013 Homelessness Policy Statement marked the Government's first policy commitment to pursue a housing-led[39] approach to solving long term homelessness.[40] Housing First offers housing without preconditions and includes a range of supports focussed on harm minimisation and supporting recovery and empowerment through Assertive Community Treatment (ACT) teams. The success of such initiatives depends not just on housing but also, crucially, on drug and/or alcohol, mental health, and community integration services being available to people who were formerly homeless. There are two key aspects to the Housing First[41] approach - immediate provision of housing without pre-conditions or no requirement of housing 'readiness' and the provision of support in housing at the level required, for as long as necessary. With Housing First, the goal is to move people out of homelessness as quickly as possible into permanent housing where tailored support services are more effective. These approaches, once properly resourced and implemented, improve the outcomes and quality of life for people who are homeless, or at risk in Ireland.

To date, emergency accommodation has formed the basis of Ireland's response to the homeless crisis including the use of private hotels, B&B's and emergency dormitory shelter beds. As a strategy, this fails to address homelessness effectively. Without the necessary supports in place people experiencing homelessness may be unable to access or sustain a tenancy or access support services. There can be issues accessing mental health services, attending primary health care facilities or utilising mental health housing programmes for active drug and/or alcohol users. People can be deemed ineligible for housing payments such as Rent Supplement, the Rental Accommodation Scheme or Housing Assistant Payment scheme if they had rent arrears in the past three years or a criminal record in the last two years. This runs contrary to the ethos of Housing First approaches and presents a real risk of institutionalisation for people in emergency accommodation.

Cost effectiveness of Housing First

Historically, an emergency-led strategy has not been effective with people spending considerable periods of their lives trapped in emergency accommodation involving the spending of high levels of statutory funding on homelessness services that have not always delivered satisfactory outcomes for households and in the long run led to additional problems of institutionalisation and dependency. The failure to deliver positive sustainable outcomes despite large scale statutory expenditure has been described as "the litmus test in delivering value for money"[42], however in the absence of the local and national political and financial commitment to Housing First we remain reliant on an emergency led response. In contrast to this approach, the rollout of Housing First for chronically homeless people who make repeated and sustained use of emergency shelters delivers positive and sustainable quality of life outcomes for people and offers some cost effectiveness and exchequer savings.[43]

[39] The terms Housing First and Housing Led are often used interchangeably for the purpose of this document we use the term Housing First.
[40] DECLG, Homelessness Policy Statement, 2013, http://www.homelessdublin.ie/sites/default/files/publications//Homeless_Policy_Statement_2013.pdf.
[41] In 2014 research undertaken by Mental Health Commission of Canada as part of the *At Home/Chez Soi study*, the largest ever study examining the effectiveness of the Housing First approach compared with the traditional staircase approach. The study followed more than 2,000 people who were homeless over a two year period across 5 Canadian cities. The findings were very clear: The Housing First intervention was twice as effective as the staircase approach in ending homelessness for people who had been long-term homeless with complex support needs. Furthermore, the intervention led to significant cost savings when compared with traditional interventions[41]. The key to the success of Housing First is its comprehensive model of support for the most 'hard core' people who are homeless with the highest level of needs.
[42] Eoin O'Sullivan, *'Ending Homelessness – A Housing-Led Approach'*, P. 24, http://www.drugs.ie/resourcesfiles/reports/EndingHomelessness.pdf.
[43] Nicholas Pleace and Joanne Bretherton, *'The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness'*, P. 25, http://housingfirstguide.eu/website/wp-content/uploads/2016/03/The-case-for-Housing-First-in-the-EU-np_and_jb.pdf.

Reduced Emergency Accommodation Usage

Significantly better outcomes and cost savings can be achieved through reduced use of emergency homeless shelters by chronically homeless people who often account for the majority of repeated and sustained emergency homeless shelter use. The average cost of providing each bed in Supported Temporary Accommodation is approximately €29,000 per annum, not inclusive of all additional statutory and non-statutory expenditure by other state and non-state bodies.[44] In Dublin, O'Donohue-Hynes (2015)[45] found that from 2012 to 2014, of the 7,254 people that used emergency accommodation just 13% (924) could be considered long stay[46] shelter residents. However, this group accounted for 52% of emergency bed nights.[47] Remarkably, Cork Simon's most recent data shows similar findings - 14% of residents in its emergency shelter in 2016 met the government's definition of long term homelessness, and this group accounted for 37% of shelter bed nights.

Better quality of life outcomes - Reduced health care costs

Reductions in the use and presentations to emergency medical and mental health services deliver significant cost savings as chronically homeless people availing of Housing First have direct access to primary health care and mental health services. This has a dual benefit of improving the general health of people who are homeless in addition to reducing hospital admissions resulting in reduced overall cost to the healthcare system. In one study, a general practitioner and nurse led response to improving hospital care for homeless people led to a 30% reduction in hospital bed days following the first year of service.[48]

Cost savings across multiple jurisdictions

Housing First has demonstrated significant cost savings across multiple jurisdictions. In the United States, a large scale study in New York found that 95% of the costs of providing Housing First were covered by the savings to health, criminal justice and other services, offsetting nearly the entire cost of implementing the programme.[49] Elsewhere in the United States, a pilot Housing First programme targeting veterans experiencing homelessness resulted in a 54% reduction in the cost of inpatient healthcare in addition to a 32% reduction in outpatient health care costs.[50] In Finland, a study of a supported housing unit demonstrated that housing with intensified support halved the use of social and health care services compared to service use during periods of homelessness. This led to average savings of €14,000 per resident per annum with total annual savings for 15 residents in the unit in question amounting to €220,000 per year.[51][52] In Canada, the Calgary Homeless Foundation reported annual cost savings of approximately $2.5 million, achieved through the delivery of Housing First for 72 homeless people, equating to an average cost saving of $34,000 per person. This dramatic reduction was largely due to significant reductions in police interactions, incarcerations and hospital stays.[53]

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[44] Ibid 11, P. 23.
[45] O'Donoughe Hynes (2015) *Patterns of homeless emergency accommodation use in Dublin: how do we compare?* Paper presented at European Research Conference Families, Housing and Homelessness Dublin, 25th September 2015
[46] Long Stay* or chronically* homeless according to typologies developed by *Aubrey et al (2013) Kahn and & Culhane (2004)
[47] Total number of emergency bed-nights available" is the total number of emergency beds available in a given period.
[48] Hewett N, Halligan A, Boyce T. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ. 2012;345:e5999.
[49] Nicholas Pleace, European Observatory on Homelessness/FEANTSA, *'Housing First',* P. 22, http://www.feantsaresearch.org/download/housing_first_pleace3790695452176551843.pdf.
[50] Montgomery A.E., Hill L., Culhane D.P., Kane V., '*Housing First Implementation Brief',* P. 5, VA National Center on Homelessness Among Veterans/U.S. Department of Veterans Affairs, 2014, https://www.va.gov/homeless/nchav/docs/Housing-First-Implementation-brief.pdf.
[51] Ministery of the Environment (2011) Asunnottomuuden vähentämisen taloudellisetvaikutukset. Helsinki: Ministery of the Environment.
[52] Ibid 11, P. 30.
[53] Calgary Homelessness Foundation, *'The Cost Benefits of Housing First'*, http://calgaryhomeless.com/wp-content/uploads/2014/06/The-Cost-Benefits-of-Housing-First.pdf.

Budgetary shortfall for essential supports

It is disappointing that Budget 2017 commitments to deliver additional funding for the provision of additional care and case management assessment and intensive addiction and mental health programmes for people using homeless services will fall €2 million short of the 2017 budgetary target of €6 million. People with the longest experience of homelessness and those with the most complex support needs must be prioritised for housing at the earliest opportunity. The Simon Communities know from experience and international evidence that this group is the most vulnerable to entrenchment in emergency shelters and rough sleeping with detrimental effects on their physical and mental health. We call for the full delivery of this commitment in 2018.

Appendix 2: Housing and homelessness crisis in numbers

- During one week in November 2017 (latest available figures), there were 8,857 people living in emergency accommodation, including 3,410 adults without dependents in their care and 1,530families composed of 2,114 adults and 3,333 children. (DHPLG, November 2017).
- On the night of 7th November 2017, there were 184 people without a place to sleep in Dublin City. Unfortunately, Dublin is the only area where an official rough sleeper count takes place, making it difficult to get a countrywide rough sleeping picture. (DRHE 2016).
- According to Census 2016, a total of 6,909 people were enumerated as homeless on Census night 2016. Unlike Census 2011 this figure does not include those people living in Long Term Accommodation (LTA) which amounted to 1,772 people on Census night 2016. Including those living in LTA a direct comparison with Census 2011 reveals a 127.9% increase in homelessness in the intervening period between Census 2011 and Census 2016, representing a total of 8.678 people.
- Homelessness and housing insecurity are more acute and visible in our cities but the Simon Communities are working at capacity countrywide – in urban and rural areas.
- There are 91,600 households on the social housing waiting list. Two-thirds of households on the list were living in the private rented sector and one fifth living with parents, relatives or friends. 5,159 households (5.6%) had at least one member considered to be homeless, a proportion which has doubled since 2013 (Housing Agency, 2016).
- Social housing commitments will take time to begin to deliver housing. This is far too long for the people we work with and those at risk of homelessness. In 2016, just 665 new social housing units were built.
- Average national rent now stands at €1,198. (Daft.ie Rental Report Q3 2017).
- *Locked Out of the Market IX* (August 2017 Simon Communities) found that 91.5% of rental properties are beyond the reach for those in receipt of state housing support.
- Over 73,000 principle dwelling mortgage accounts are in arrears. 44% of all mortgage arrears are in arrears of over 720 days (Central Bank of Ireland, June 2017).
- At the end of June 2017, 19,627 or 15% of buy-to-let mortgages, were in arrears of more than 90 days. (Central Bank of Ireland, June 2017).
- 395,000 people are living in consistent poverty in Ireland. (CSO Survey on Income and Living Conditions 2016).
- 785,000 people are at-risk of poverty in Ireland. (CSO Survey on Income and Living Conditions 2016).
- In 2016, 21% of the population experienced two or more types of enforced deprivation. (CSO Survey on Income and Living Conditions 2016).
- According to Census 2016, there are 183,312 vacant houses nationwide.