Simon Communities in Ireland

Submission to the Oireachtas Committee on the Future of Healthcare

August 2016

Executive Summary

This submission looks at healthcare specifically as it relates to people who are homeless or at risk of homelessness. The submission opens with a series of recommendations across Health; Mental Health; Alcohol and Drug Use; Support for the Implementation of Housing First; Dual Diagnosis and Complex Needs; Older People; and Women. This is followed by a brief overview of homelessness, the reasons people become homeless and the current housing and homelessness crisis. Building on this, the submission then outlines the health issues experienced by people who are homeless with regard to their physical health, mental health, problematic drug and alcohol use; and dual diagnosis and complex needs. This progresses to a discussion of the importance of housing first as a proven concept for the delivery of targeted clinical supports for people who are homeless. The barriers to accessing healthcare are then examined with specific reference to those experienced by people who are homeless. The submission concludes with a brief examination of the beneficial cost implications associated with the delivery of targeted health care and housing services for people who are homeless as experienced in Ireland, the UK and Australia.

The content of this submission is built on a number of data sources that measure the incidences of health issues experienced by people who are homeless in Ireland. A number of additional resources are relied on to give context and greater detail in relation to concepts mentioned, current health strategies across the spectrum of healthcare in Ireland, and international practice with regard to the delivery of targeted healthcare and housing services for people who are homeless. The content is further influenced by the front line experiences of the Simon Communities around the country.

The data relied on in this submission shows that people who are homeless experience a complex range of health issues and complications both as a cause and consequence of homelessness. This is exacerbated by a number of barriers in accessing healthcare specific to people who are homeless. Resources referenced in this submission point to a number of cost saving implications attached to the wider provision of primary healthcare services for people who are homeless in addition to achievable healthcare cost savings linked to the delivery of Housing First for people who are homeless.

Recommendations discussed include but are not limited to the following:

- 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.
- Increase funding for mental health services to 8.24% of the national health budget as recommended in 'A Vision for Change'. This should include the dedicated ring fencing of funding streams for the full implementation of the commitments contained in 'A Vision for Change'.
- Alcohol and drug services must be resourced to target the needs of people who are homeless with alcohol and/or drug related problems in line with the four tier model. This should include rapid access to substitution treatment, detoxification, rehabilitation/recovery and aftercare countrywide to include all substances.
- Extend Housing First nationwide and put in place and maintain funding for Assertive Community Treatment (ACT) Teams.
- Improve health outcomes for people with dual diagnosis by ensuring greater collaboration between drug and alcohol services and general mental health services.
- Appoint a Palliative Care Coordinator to enhance access to end of life care for people who are homeless as recommended in the Simon Communities of Ireland exploratory research '*Homelessness, Ageing and Dying*'.
- Establish targeted services for women and trauma informed responses to deal with the complexity of need.

The submission does not review in detail existing Government health strategies but does where possible reference the interconnectedness of these strategies with health issues specific to people who are homeless.

Introduction

Housing is a key social determinant of health which impacts on the ability to live a healthy life (FEANTSA). The World Health Organisation defines health as "a state of complete physical, mental, and social well-being and not merely the absence of infirmity."[1] Poor quality housing can impact greatly on health and wellbeing with the absence of a home being detrimental. In addition, chronic conditions occur more frequently among people in lower socioeconomic groups and those who are more vulnerable in society. (Institute of Public Health, 2010).[2] It is widely evident that there is a strong link between homelessness, poor housing and health. The relationship is complex in that health problems can cause a person to become homeless while being homeless can exacerbate particular health conditions. Access to mainstream health services can be difficult for people experiencing homelessness[3]. Research has found that people who are homeless often have higher healthcare needs, are more at risk of illness and have earlier mortality rates than the general population.[4] Although the health conditions experienced by people who are homeless are very often the same as those experienced by the general population, they occur more frequently, are often more severe and develop at a younger age. In addition, blood borne diseases such as HIV, Hepatitis and TB are more common among people who are homeless than the general population[5]. People who are homeless are less inclined to access general healthcare services and it is often when a crisis occurs that they present to Accident & Emergency departments (A&E). This is one of the best examples of 'Inverse Care Law' where those who most need a health service are the least likely to receive it.[6]

Recommendations

Health

- 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.
- 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.
- Undertake a review of the efficacy of catchment areas in relation to access to drug detoxification, treatment and aftercare and mental health service to ensure those that need the services most have ease of access especially vulnerable target groups such as people who are homeless.
- Establish multidisciplinary and patient-centred approaches to health treatment across the board.
- Agree a mechanism to capture the views of service users which are central to the design and delivery of services across the health system.
- Resource the delivery of step up/step down beds for people who are homeless being treated for chronic illness.
- Ensure sufficient resourcing of case management teams in all regions.

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[1] http://www.who.int/about/definition/en/print.html

[2] Balanda KP, Barron S, Fahy L (2010) *'Making Chronic Conditions Count: Making A systematic approach to estimating and forecasting population prevalence on the island of Ireland"* Institute of Public Health in Ireland
http://www.publichealth.ie/sites/default/files/documents/files/Making%20Chronic%20Conditions%20Count%20Exec%20Summary.pdf

[3] Simon Health Snapshot Report (2011)
http://www.simon.ie/Portals/1/Publications/Simon's%20National%20Health%20Snapshot%20Study%202011.pdf

[4] Simon Communities in Ireland '*Homelessness, Ageing and Dying'* (2014) http://www.simon.ie/HomelessnessAgeingandDying/index.html#/14/

[5] 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

[6] Cited in Feantsa Health Working Group Paper (2013) *'Health and Well-being for All – Holistic Health Services for People who are Homeless'*

- Develop, resource and implement discharge protocols for general hospitals, mental health services and drug treatment services for people who are homeless in conjunction with primary care networks and local primary care teams. Nobody should be discharged back into homelessness.
- Resource the delivery of specialist intermediate care health facilities to provide step down facility from hospital following medical and surgical treatment and to reduce hospital stays.
- Implement the prioritised recommendations of the National Hepatitis C Strategy 2011–2014.[7]
- Reverse cuts to the HSE homelessness budget and health services in general.
- Have representation from homeless healthcare providers on Primary Care Network teams to progress and highlight the unique healthcare needs of homeless people.

Mental Health

- Fill essential posts in mental health services to ensure nationwide coverage of Community Mental Health Teams.
- Clear identification of CMHT team with responsibility and accountability for people who are homeless in each catchment area. CMHT to be equipped to offer assertive outreach.
- 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'* [8]and the '*National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self Harm'* and ensure interagency responses. [9]
- Increase funding for mental health services to 8.24% of the national health budget as recommended in *'A Vision for Change'*. This should include the dedicated ring fencing of funding streams for the full implementation of the commitments contained in '*A Vision for Change'*.
- Put in place an out of hour's self-harm nursing service in all hospital accident and emergency departments.
- Provide for a dedicated counselling service to provide out of hours outreach support to clients in homeless accommodation services who are expressing suicidal ideation.
- Consideration should be given to resourcing homeless services to introduce suicidal ideation and self-harm services on site because going to a hospital is not always the answer.
- It is essential to ring-fence a dedicated funding stream for the full implementation of *A Vision for Change.*
- The proposal in the *Implementation Plan on the State's Response to Homelessness* to provide a dedicated Community Mental Health Nurse in each ISA[10] area to support the needs of people who are or at risk of homelessness needs to be actioned. This is supported n the *Report of the Committee on Housing and Homelessness* (2016).
- Monitor, record and respond to breaches of discharge protocols for people who are homeless being discharged back into homelessness.
- Develop onsite counselling/psychological services in homeless accommodation services to provide trauma informed care.

Alcohol and Drug Use

- Alcohol and drug services must be resourced to target the needs of people who are homeless with alcohol and/or drug related problems in line with the four tier model[11]. This should include rapid access

[7] https://www.hse.ie/eng/services/Publications/HealthProtection/HepCstrategy.pdf

[8]Specialist adult teams should be developed, comprising one consultant psychiatrist, one doctor in training, four substance misuse and dependency key workers/ counsellors, two clinical nurse specialists, one clinical psychologist, two social workers and one occupational therapist, in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder. Each member should have specialist expertise in the field of addiction in addition to mental health expertise.

[9] https://www.hse.ie/eng/about/Who/clinical/natclinprog/mentalhealthprogramme/selfharm/nationalclinicalprogselfharm.pdf

[10] 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.

[11] http://www.drugs.ie/resourcesfiles/reports/3966-42381118.pdf

to substitution treatment, detoxification, rehabilitation/recovery and aftercare countrywide and include all substances.

- It is essential to provide funding for step down options and support for people once they have completed treatment so they have accommodation to go to and have a support plan in place. We welcome the commitment contained in the *Action Plan for Housing and Homelessness* that through the new National Drugs Strategy, drug rehabilitation pathways will be linked to sustainable supported tenancy arrangements. It is essential that such approaches are underpinned by a Housing First approach to addressing homelessness.
- In-reach support for people while in treatment to prevent homelessness on discharge.
- We welcome the commitments contained in the *Action Plan for Housing and Homelessness* for enhanced supports for people who are homeless with mental health and drug and/or alcohol issues in addition to commitments for increased funding for people with chronic and enduring health needs.
- The Drugs Initiative budget has seen cuts of 37% in the past six years[12]. At the very minimum these cuts need to be reversed to ensure adequate support services are available. These cuts have had an impact on people who are homeless and are impacting on waiting times and waiting lists.
- Rapid Access to treatment. People who are homeless often have to wait in homeless services until a treatment place becomes available.
- Harm reduction must be at the heart of homeless and drug service provision and is key to the success of Housing First approaches including the rollout of Naloxone and widespread availability and training on same and introduction of Medically Supervised Injecting Centres (MSIC).
- Implement the recommendations contained in HSE Introduction of the Opioid Treatment Protocol report.[13]
- Increase incentives and access for GP's to encourage them to become level 2 GP's under the Methadone Protocol[14] for methadone prescribing and methadone management. In addition there is a need to increase the number of methadone clinics in rural areas so people don't have to travel to city areas daily to collect daily doses of methadone.

Support for the implementation of Housing First (housing plus support)

- Extend Housing First nationwide and put in place and maintain funding for Assertive Community Treatment (ACT[15]) Teams.
- The roll out of Housing First nationwide should be inclusive of Regional Homeless Fora to ensure the complex health needs of homeless people are met. This should include the development of formal protocols to fund, second or broker in specialist health professionals onto Housing First teams.
- 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.

Dual Diagnosis and Complex needs

- Improve health outcomes for people with dual diagnosis by ensuring greater collaboration between drug and alcohol services and general mental health services.[16]

[12] http://www.citywide.ie/news/2015/03/04/citywide-calls-for-confirmation-of-appointment-of-minister-for-drugs/ ibid.
[13] http://www.drugs.ie/resourcesfiles/reports/Opioid_Treatment_Protocol.pdf
[14] http://www.drugsandalcohol.ie/6721/2/Butler_1983_The_Making_of_the_Methadone_Protocol.pdf
[15] https://www.centerforebp.case.edu/practices/act
[16] The National Advisory Committee on Drugs (NACD) (2005) commissioned a report on dual diagnosis. They suggested that closer collaboration between addiction programmes and general mental health services was needed in order to improve outcomes for individuals with dual diagnosis. Overall, service users with dual diagnosis and complex needs respond well to case management, and use of multi-profession teams. http://www.drugs.ie/resourcesfiles/research/2004/Dual_Diagnosis.pdf.

- Establish a post of National Policy Coordinator to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol use and their linkage to mental health services.
- Ensure coordinated responses for people with co-morbid mental health, people with dual diagnosis (mental health and drug and/or alcohol issues) and people experiencing homelessness. We welcome the commitment contained in the *Action Plan for Housing and Homelessness* for a more coherent government wide response. We continue to support the call in the *Report of the Committee on Housing and Homelessness* (2016) for increased resourcing for and improved coordination between HSE mental health services and homeless service providers.
- Identify the clients 'falling through the gaps' such as those with mild- moderate intellectual disabilities or late or undiagnosed autism in the 80's which resulted in them ending up in homelessness and resource responses to address their needs.

Older people

- With an aging population of people who are or have experienced homelessness there is a need to plan for and address their deteriorating health and make provisions for end-of-life care for people who are homeless.
- Appoint a Palliative Care Coordinator to enhance access to end of life care for people who are homeless as recommended in the Simon Communities of Ireland exploratory research '*Homelessness, Ageing and Dying'*.[17]
- Ensure that palliative care beds are accessible to people who are homeless.[18]

Women

- Research suggests that women who are homeless are more likely to have higher health and mental health needs than men and to have particular past experiences that require a gender sensitive approach to policies and services.[19]
- Need to establish targeted services for women and trauma informed responses to deal with the complexity of need.

[17] http://www.simon.ie/HomelessnessAgeingandDying/pubData/source/Homelessness_Ageing_and_Dying.pdf.
[18] Ibid.
[19] Mayock et al. (2015), Women and Homelessness in Ireland: Service use patterns and service needs; St. Mungos (2014), Rebuilding Shattered Lives: Getting the right help at the right time to women who are homeless or at risk.

Homelessness

People become homeless for a whole range of complex and overlapping reasons. Primary causes relate to poverty, inequality and lack of affordable housing, often coupled with systems failures and individual circumstance. The Simon Communities come across many reasons why people become homeless and we deal with them all. Many of the people we work with have been disadvantaged and isolated from a young age; they have been failed by the state time and time again. Homelessness is extremely traumatic and damaging having a serious impact on people's mental and physical health, as well as their overall wellbeing. When people think of homelessness, they often think of rough sleeping. However rough sleeping is the most extreme form of homelessness; it also includes people who are living in shelters and emergency accommodation, and other people who have no place of their own and therefore end up staying with family and friends, people who are living in inadequate housing or those at risk of homelessness who are living under threat of insecure tenancies or eviction. 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.

Homelessness can happen as the result of a crisis or an accumulation of crises in a person's life. It can build up over time, sometimes years. With access to affordable housing and the right supports people can move out of homelessness quickly. Limited access to housing and support services is increasing the risk of homelessness and is preventing people moving out of homelessness. It is vital to ensure people can remain in their communities where they have family and support networks when they run into housing and financial difficulties, often times when these supports are most important. Therefore responses must be nationally driven but locally resourced and delivered.

The housing and homeless crisis can only be addressed effectively with integrated plans across all forms of housing and the provision of support in housing. We must learn from past mistakes and change expectations - we need to expect that people will move on from homelessness quickly to a decent, affordable home of their own. Some may need support – visiting or on-site. This needs to be the expectation of people who are homeless, the expectation of staff and volunteers in homeless services and the expectation of our Government. We need to agree that every man, woman and child in this State is entitled to an affordable, safe and secure home.

Homelessness and health

There is a complex relationship between homelessness and health incorporating physical health issues, mental health issues, problematic drug and alcohol use and complex needs. Heath 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. These are all explored individually below.

Physical Health

The physical health of a person who is homeless can be exacerbated due to not having a stable home. Health conditions can also develop as a result of homelessness, and people who are homeless are more at risk of developing an illness than the general population.

Homelessness: An Unhealthy State report 67.8% of participants in the study had a chronic physical health diagnosis, such as diabetes, high blood pressure, arthritis, heart disease, epilepsy, tuberculosis, and chronic

respiratory & stomach problems[20]. Blood borne viruses such as, hepatitis, HIV etc. are also high among people who are homeless and they are more at risk of contracting one of these diseases. 10% of respondents in the 2011 Simon Communities Snapshot Report had a Hepatitis C diagnosis.

The 2011 Simon Communities Snapshot Report also found that 65% of the 603 participants had at least one diagnosed physical health condition. Dental related issues were among the most frequently occurring health issue among respondents, while chronic diseases such as asthma and other respiratory problems, diabetes, migraines, and arthritis were also very dominant among respondents. Further support for these findings can be found in a recent study by the Royal College of Surgeons in Ireland and Doctor Austin O'Carroll of Safetynet Dublin which examined '*Health and use of health services of people who are homeless and at risk of homelessness who receive primary healthcare in Dublin*'. [21]

Mental Health

Mental health issues can be a reason for people becoming homeless in the first place while the experience of being homeless can impact on a person's mental health, deteriorating the longer a person remains homeless. In *Homelessness: An Unhealthy State* it was reported that 58% of participants in their study had at least one mental health condition. 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. This study also reported self-harm and attempted suicide rates among participants. 13.4% 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 highlights people who are homeless as a priority group.

The 2011 Simon Communities Snapshot Report found 47% of respondents reported having been diagnosed with at least one mental health condition. Depression was the most commonly reported mental health condition, reported by 30% of respondents. Other mental health conditions reported included schizophrenia, panic attacks, bipolar disorder and social anxiety. Staff also identified undiagnosed mental health conditions among respondents. There were 154 participants that showed signs of at least one undiagnosed mental health condition. The most frequently occurring conditions included mood disorders and anxiety disorders. Mental decline[22] was also present in 23 of the participants who had an undiagnosed mental health condition. Nineteen percent of participants had self-harmed and 17% had attempted suicide within the previous six months.

Problematic Drug and Alcohol Use

Problematic drug and/or alcohol use can put people at an increased risk of homelessness, and can also be caused and/or exacerbated by traumatic experiences, including homelessness. The *Homelessness: An Unhealthy State* report 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.

[20] 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

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

[22] Mental decline is a decline in mental ability which can affect memory, thinking, problem-solving, concentration and perception. http://www.mentalhealthireland.ie/

Some of the Simon Communities have seen an increase in the use of opiate drugs, prescription drugs (in particular, benzodiazepines) and also synthetic benzodiazepines drugs. Drugs from Head Shops and the use of 'legal highs[23]' are very difficult to control. Although many head shops have now closed 'legal highs' are still accessible online. It is very difficult to know what substances a person has taken if they were purchased/secured online. A report by European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol (April 2016) found that the use of 'Legal Highs' shows no signs of decreasing across Europe and there are challenges for Ireland in legislating for these drugs as they are quickly developed and disposed of; as soon as a ban is introduced for one substance another is developed quickly to replace it[24].

The 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.

Alcohol use

That health snapshot study found that alcohol use was highest among respondents living in high-support housing and emergency accommodation. 70% of high-support housing residents and 64% of emergency accommodation residents that participated in the study reported alcohol use. The study found that 28% of all participants had health issues directly related to their alcohol use, and that 9% of the respondents had attended a detox facility in previous 12 months. Forty four percent of respondents who indicated that they were current alcohol users at the time of the study also had alcohol related health issues. The most common alcohol related health issues included; falls/head injuries, memory loss, gastric problems, liver damage and seizures.

Drug Use

The snapshot study found the highest level of drug use was found among people sleeping rough and those using emergency accommodation. Heroin was the most frequently used drug among participants, with more than 58% saying they used this drug. Cannabis was the second most frequently used drug with 47% of participants reporting that they use it. Forty one percent of people reported taking methadone; with 29.1% using prescribed methadone and 12.2% using un-prescribed methadone.

Polydrug use

The health snapshot study found that levels of polydrug use[25] was high among drug users with 76% of drug users saying they used more than one drug. 28% said they used a combination of two drugs and 45% of drug users said they used three drugs. Fifty two percent of those currently using drugs at the time of the study said they had used drugs intravenously (IV) in the previous 12 months, half of which said they experienced health complications as a result of IV drug use.

Problematic drug and/or alcohol use can lead to a range of physical and mental health conditions. Falls/head injuries and memory loss were the highest reported health problems caused by alcohol use. Fifty percent of those who were currently using drugs intravenously at the time of the snapshot study reported experiencing health complications as a result. The most frequently reported conditions included abscesses, Hepatitis B and/or Hepatitis C, overdose and vein damage.

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[23] Legal highs are substances that mimic the effects of illegal drugs, but are not currently controlled by the Misuse of Drugs Act. Legal highs can be purchased in Head Shops and on the internet http://www.aldp.ie/resources/legal_highs

[24] Article in Journal.ie 5th April 2016 *Ireland is the biggest user of legal highs in Europe as their growth shows 'no signs of a slowdown'* http://www.thejournal.ie/legal-highs-new-drug-report-2699032-Apr2016/
http://www.emcdda.europa.eu/system/files/publications/2373/TD0216072ENN.PDF

[25] Polydrug use is concurrent drug use, which involves a person using at least two substances during the same time period http://www.nacda.ie/images/stories/docs/publicationa/nacdpolydrugusebulletin5.pdf

Dual Diagnosis and Complex Needs

A person who is homeless very often has multiple needs or complex needs[26], such as problematic drug and/or alcohol use, mental health difficulties, physical health difficulties, personality or behavioural disorder, challenging behaviour and vulnerability. This makes it very difficult for people to be in contact with all the various services they may need at one time. If one issue was to be resolved, other issues would still be cause for concern (Homeless Link, 2002)[27].

The *Homelessness: An Unhealthy State* report found that 47% of participants had a mental health diagnosis and a self-diagnosed drug and/or alcohol problem. 35% of participants had a mental health diagnosis and current illicit drug use.

According to the Simon Communities Health Snapshot study, people who are homeless are more likely than the general population to experience complex needs, including a dual diagnosis of mental health and problematic drug and/or alcohol use due to environmental factors, in particular a lack of supported housing. It was very difficult to ascertain how many respondents had dual diagnosis and complex needs but 20% respondents were identified as having a diagnosed mental health condition as well as alcohol and drug related conditions.

People with dual diagnosis can find it very difficult to access services. They often fall between two stools with mental health services suggesting they deal with their drug issue first and vice versa. International best practice would argue that the two issues should be treated at the same time and in a co-ordinated way.

Housing First: Addressing Homelessness Effectively

There is a strong and well documented association between the experience of long term homelessness and a range of complex health and related needs. Housing First programmes are internationally considered to represent best practice in housing people who are long term homeless with complex needs. People with physical health, mental health, dual diagnosis and complex needs often remain trapped in homelessness. Without the necessary supports in place they are unable to access or sustain a tenancy or access support services. There can be issues accessing mental health hospital, 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 Rental Accommodation Scheme (RAS) or Housing Assistant Payment (HAP) 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 those people in emergency accommodation.

Housing First offers housing without preconditions and offers 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 tenants who were formerly homeless. *Vision for Change – report of the expert group on mental health policy* highlights the lack of adequate housing and accommodation options for enabling people with mental health issues to move through the different stages of recovery and progress towards independent living[28]. However, since 2010 the HSE budget for homelessness has been cut by 20% and the Drugs Initiative budget has seen cuts of up to 37%

[26] 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

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

[28] Vision for change – the Report of the Expert Group on Mental Health Policy (2006) http://health.gov.ie/wp-content/uploads/2014/03/vision_for_change.pdf

over the past six years. These cuts have had an adverse impact on people who are homeless and on access to treatment and one-to-one supports.

Emergency accommodation has formed the basis of Ireland's response to the homeless crisis. In some cases this has included hotel rooms and B&B's and in others additional shelter beds, often dormitory style, have been provided. As a strategy this fails to address homelessness effectively and in the long run can lead to additional problems of institutionalisation and dependency. A broad Housing First strategy, focused on people who are long term or repeatedly homeless, will substantially reduce the number of shelter beds needed and address rough sleeping and long term homelessness effectively. Analysis of shelter usage statistics in both Cork and Dublin show that a relatively small proportion of people who become homeless account for the majority of the emergency beds put in place to address the crisis. In Dublin, O'Donohue-Hynes (2015)[29] found that from 2012 to 2014, of the 7,254 people that used emergency accommodation just 13% (924) could be considered long stay[30] shelter residents. However this group accounted for 52% of emergency bed nights[31]. Remarkably, Cork Simon's most recent data mirrors that finding - 12% of residents in its emergency shelter in 2015 met the government's definition of long term homelessness, and this group accounted for 51% of shelter bed nights. These statistics clearly suggest that a strong focus on housing people who are long term homeless will have the greatest impact on freeing up emergency bed-nights and thus eliminating rough sleeping. We welcome the commitment to triple Housing First tenancies in the Dublin area by 2017. We encourage the DHPCLG to set and publish attainable tenancy targets with regard to the roll out of Housing First nationally.

There are two key aspects to the Housing First[32] approach - immediate provision of housing without pre-conditions or the 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, improve the outcomes and quality of life for people who are homeless, or at risk in Ireland. Housing First approaches involve three dimensions of support:

Housing supports: The initial intervention of Housing First is to help people obtain and maintain their housing, in a way that takes into account client preferences and needs. Key housing supports include; finding appropriate housing; supporting relations with landlords; applying for and managing rent subsidies; assistance in setting up apartments.

Clinical supports: This 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.

Supports towards Community Integration: These supports are intended to help individuals and families improve their quality of life, integrate into the community and potentially achieve self-sufficiency. They may include: life skills; engagement in meaningful activities, income supports, assistance with employment, training and education, and community (social) engagement.

[29] 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

[30] Long Stay* or chronically* homeless according to typologies developed by *Aubrey et al (2013) Kahn and & Culhane (2004)

[31] Total number of emergency bed-nights available" is the total number of emergency beds available in a given period.

[32] 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[32]. 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.

Accessing Healthcare Services for People who are Homeless

There is the aspiration that every person in Ireland is entitled to access a wide range of community and hospital health services, and where income is an issue, that this is accessed through a medical card or at a reduced cost, with some services free of charge if referred by GP[33]. (www.HSE.ie). The Health Service Executive (HSE) Transformation Programme 2007-2010 stated that by 2010 "*Everybody will have easy access to high quality care and services that they have confidence in and that staff are proud to provide".*
The HSE's aim was to place clients at the centre of the care continuum and this is particularly relevant in the context of people who are homeless[34].

People who are homeless and those that provide services for people who are homeless have reported many challenges that they face when trying to access services. Cutbacks in health and HSE budgets since the onset of the financial crisis have had a detrimental impact on access to services. Despite there being access to health care in Ireland for all, many people who are homeless only access health services when they are in crisis or when illness is well developed and severe, a point at which they access health care through emergency departments. (Partnership for Health Equity, 2015)[35]. This is a prime illustration of the inverse care law in operation, whereby those that are most likely to need services are the least likely to get them. Some of the Simon Communities in Ireland reported that having treatment services and multi-disciplinary teams in place is very advantageous however barriers to accessing off-site health care for people who are homeless still exist.

Stigma

People who are homeless often avoid accessing health care services as there can be stigma that is still attached to being homeless[36]. Other reasons identified in the *Homelessness: An Unhealthy State* report for not presenting to primary care services included difficulties with complex administrative forms, difficulties making and keeping appointments due to the nature of homelessness; being too busy to attend due to other priorities such as looking for food, shelter, money, and problematic alcohol and/or drug use[37].

Cuts to Health and HSE Budgets

The impact of the crisis and cuts to HSE budgets are still being felt in health and homeless services. These cut-backs to funding and lack of resources have impacted most on high risk groups, especially on people who are homeless. Some health services that were available have been amalgamated with others or have almost disappeared, making it more difficult for people to access.

Catchment Areas

Catchment areas can pose a problem for people when trying to access services. For example, Dublin Simon Community residential detoxification services operate within the Dublin Southside catchment area, and although the North-side services operate in the same surrounding area, people using the residential detox service are unable to access North side catchment areas services. The amalgamation of Mental Health services between Galway City and County and Roscommon is making it more difficult for people to access these services. Waiting times for appointments are longer and it can be more difficult for people to travel to city centre services.

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[33] http://www.hse.ie/eng/services/Find_a_Service/eligibility.html
[34] HSE Transformation Programme 2007-2010 http://www.hse.ie/eng/services/Publications/corporate/transformation.pdf
[35] 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
[36] Simon Communities in Ireland (2013) *'Homelessness, Ageing & Dying'* http://www.simon.ie/HomelessnessAgeingandDying/index.html#/26/
[37] Ibid

Flexibility of Services

Many challenges continue to be experienced by both service-user and service provider when linking with mental health services. Barriers to accessing services continue to be experienced. The absence and inflexibility of some services can hinder the progress of people moving out of homelessness. If a person misses an appointment with psychiatric services, they can be discharged from the waiting list for this service resulting in another referral being required.

Discharge from Institutional Settings

Discharging people from institutional settings e.g. hospital/prison/care system into homelessness remains an issue. Discharge protocols must be published, implemented and resourced for those leaving state care or residential institutions. This is supported in the *Report of the Committee on Housing and Homelessness* (2016). The *Rebuilding Ireland: Action Plan on Housing and Homelessness* does not contain detailed targets in this regard.

Case-Management Teams

There are no case-management teams in some regions. Meetings take place but often do not involve the patient, family members or a person's key worker. This goes against the person-centred approach.

Out-of-Hours Services

There are now self-harm nurses in most Accident & Emergency (A&E) departments of Irish hospitals. While this is a positive development, the nurses are only available between the hours of 9-5 Monday to Friday; times at which people are less likely to present to A&E with such issues[38]. An out of hour's service is not available, although protocols exist for nurses to follow-up in cases where presentations are made outside of service hours.

Mental Health Services

One of the major challenges is that posts in mental health services have been extremely slow to be filled, leaving some areas without a full Community Mental Health Team for long periods of time[39]. Staffing in Mental Health services is still 22% below the recommended level outlined in *A Vision for Change*.[40] Although funding for mental health services was restored to the recommended €35 million in Budget 2016, there are still significant shortfalls in funding for mental health services which, at just 6.5% of the health budget, is still well below *A Vision for Change* recommended level of 8.24%.[41]

Drug and Alcohol Services

A full range of harm reduction services and responses is not available to all that need them. There are also a limited number and spread of residential treatment and rehabilitation places across the country. This results in long waiting lists and people having to travel to access services only to have to return to their county of origin following treatment/rehabilitation.

Lack of Specialist Services

Simon Communities have reported extreme difficulty in supporting people with complex needs or dual diagnosis as there is no designated service in some regions. Often it appears that no one will take

[38] Interview with Galway Simon Community Staff
[39] Simon Communities in Ireland Pre-Budget Submission 2016 'Changing the Forecast' 2015 www.simon.ie
[40] Mental Health Reform online petition (2015) https://www.mentalhealthreform.ie/news/thousands-call-for-government-to-invest-in-irelands-mental-health/
[41] Department of Health *A Vision for Change* 2006

responsibility resulting in people being passed back and forth from drug and alcohol service to mental health services.

Services for Older People who are Homeless
There is a clear recognition within the health services that people who are homeless have a reduced life expectancy and that those aged 50 and over who are homelessness often have health needs more generally associated with people who are older. The provision of appropriate housing, along with adequate healthcare support is needed. There is also a clear need to plan for and address end-of-life care for people who are homeless. In the study *Homelessness, Aging and Dying* (2014)[42] many older people who are homeless reported worrying about what would happen to them as their health deteriorated.

Services for Women who are homeless.
Women's health experiences, drug and alcohol use and homelessness can differ to men's experiences in terms of causes, experiences and pathways out of drug use/homelessness. In research carried out by the Simon Communities *Women, Homelessness and Service Provision* (2015)[43], women who participated in the study identified a number of health issues they had or were currently experiencing. These included problematic drug and alcohol use, mental health issues, sexual abuse and harassment, physical illnesses and pregnancy related health needs.

Accessing healthcare in a rural setting
Responding to the healthcare needs of people who are homeless in a rural setting is accentuated by not having access to services. Homeless service users have to travel significant distances sometimes outside their own county to access health services. The additional costs incurred by Homeless Services because of rural isolation and poor transport infrastructure has not been recognised by State funders of homeless services.

Healthcare Cost Implications

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. In a recent study by the Royal College of Surgeons in Ireland and Dr. Austin O'Carroll of Safetynet Dublin, general practice was identified as an important setting to meet the healthcare needs of homeless people 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.

Additional research by the Australian Housing and Urban Research Institute has shown that the provision of housing for people who are homeless has led to a significant decrease in health service use when compared to the period before they were in such tenancies. In terms of the cost to Government including the provision of the tenancies in question, the potential health costs avoided represent an offset to the cost of providing social housing support.[44]

A 2012 report by the UK government revealed the beneficial cost implications of providing comprehensive health supports to people within stable accommodation as opposed to more piecemeal supports provided when the same people were experiencing homelessness. The research which examined two case studies

[42] http://www.simon.ie/HomelessnessAgeingandDying/index.html
[43]http://www.simon.ie/Women_Homelessness_and_Service_Provision/pubData/source/Women%20Homelessness%20and%20Service%20Provision.pdf
[44] https://www.ahuri.edu.au/__data/assets/pdf_file/0021/8526/AHURI_Final_Report_No265_What-are-the-health,-social-and-economic-benefits-of-providing-public-housing-and-support-to-formerly-homeless-people.pdf?utm_source=website&utm_medium=report.PDF&utm_campaign=https://www.ahuri.edu.au/research/final-reports/265

showed that drug treatment, detoxification and mental health support costs were reduced from £16,000 to £2,700 and £32,000 to £3,000 when supports were provided in a stable accommodation setting.[45]

Conclusion

We welcome the opportunity to make this submission to the Oireachtas Committee on the Future of Healthcare. People who are homeless suffer from a range of health issues which include but are not limited too 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, 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 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. We believe the work of the Committee can have a beneficial impact on the improvement of existing 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

[45] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

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 40 years. The Simon Communities deliver support and service to over 7,500 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 www.simon.ie

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 and Homelessness Crisis in numbers

- During one week in June 2016 (latest available figures), there were 6,358 men, women and children in emergency accommodation across the country; a 32 % increase from the same week in June 2015. This included 2,695 adults with no dependents in their care and 1,078 families made up of 1,457 adults and 2,206 children. (DECLG, 2016).
- On Census Night, 24th April 2016, there were 171 people without a place to sleep in Dublin City. This included 102 people sleeping rough and 69 people sheltering at the Nite Café. 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 2015).
- Figures from Cork Simon Community indicate that rough sleeping in Cork City increased nine-fold in four years (2011-2015) from 38 people sleeping rough in 2011 to 345 people sleeping rough in 2015.
- 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 at least 90,000 people on the social housing waiting list. (Housing Agency, 2014).
- 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. Social housing output for 2015, reached 1,030 new builds and acquisitions, with new builds accounting for 75 units. (DECLG, 2016). This is below the Social Housing Strategy target of 18,000 new units for the period 2015-2017.
- The average rent nationwide has risen by over one third since bottoming out in 2011 and has surpassed its 2008 peak. The average national rent is now €1,037 (Daft.ie Rental Report Q2 2016).
- *Locked Out of the Market III* (Jan 2016 Simon Communities) found that 95% of rental properties are beyond the reach for those in receipt of state housing support. Of all the properties available to rent in the eleven regions studied, only one was available for a single person see http://www.simon.ie/Publications/Research.aspx
- 41.2% of all accounts in mortgage arrears are in arrears of over two years. (Central Bank of Ireland, 2016).
- At the end of December 2015, 23,344 or 17% of buy-to-let mortgages, were in arrears of more than 90 days. (Central Bank of Ireland, 2016).
- 750,000 people are living in poverty in Ireland (*Poverty, Deprivation and Inequality* (July 2016) Social Justice Ireland Policy Briefing).
- Since 2007 the deprivation rate, which looks at the number of people forced to go without at least 2 of 11 basic necessities examined, in Ireland has doubled - 29% of the population or 1.3 million people are experiencing deprivation (Social Justice Ireland ibid).